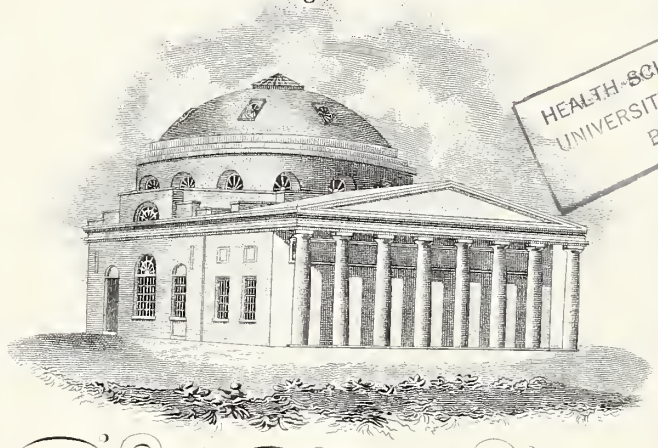
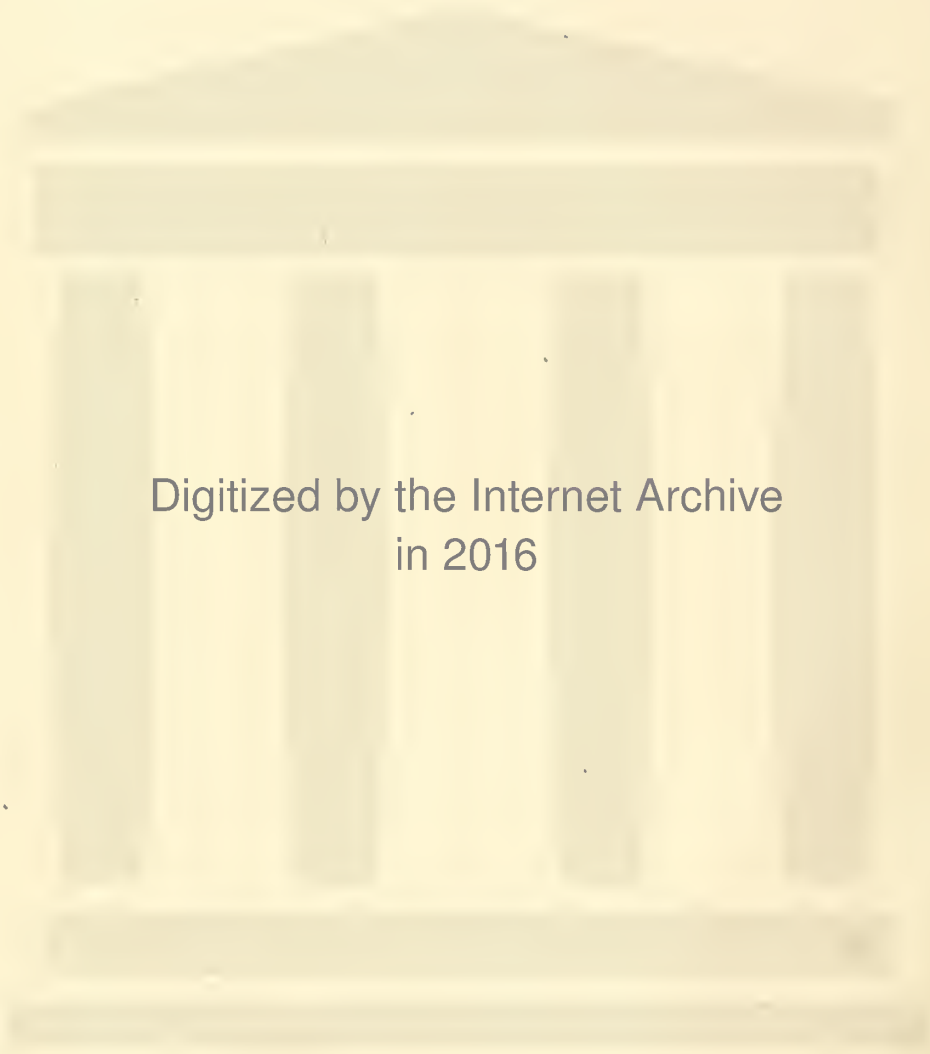
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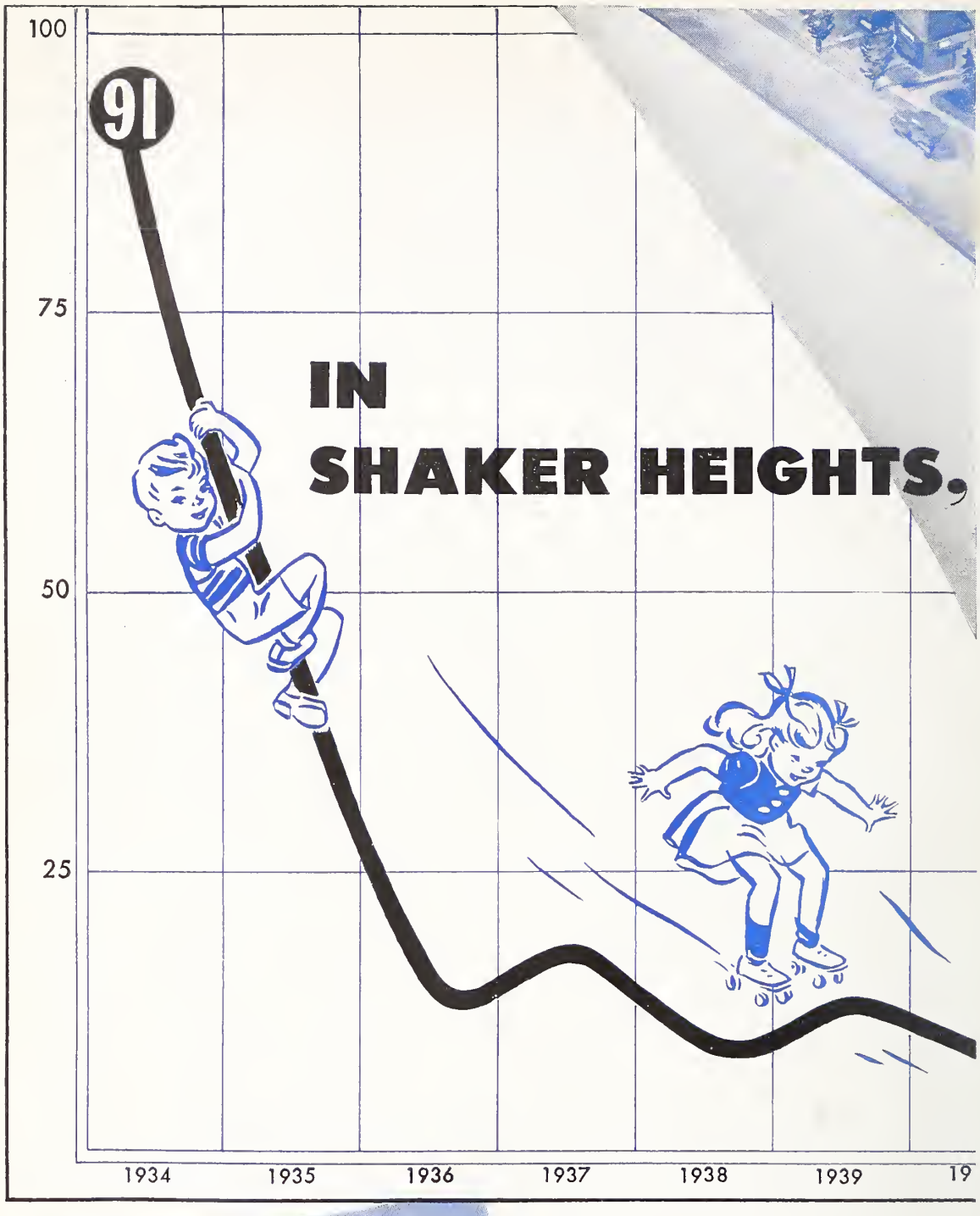
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INDIANA'S HEALTH PROGRAM*

RALPH F. GATES

Governor of Indiana

INDIANAPOLIS

It is indeed a privilege and an honor to appear before you this evening. Earlier today it was my privilege to talk before the James Whitcomb Riley Cheer Guild, an organization with which many of you are familiar—an organization of women which has done so much for our James Whitcomb Riley Hospital at our medical center. So, I dedicated this day to "hospital day and medical day." I am happy to be here tonight—happy to be with this great group of professional people who have contributed so much, not only in the prosecution of the war, but on the home front during these trying days when you were obliged to do the work of two people instead of one. The State of Indiana is very grateful for the services you have rendered.

I come from a county seat town—a little county seat of about 4,500. In that little town my best friends were in the medical profession. Lawyers and doctors usually walk together—after some slick salesman of some slick stock scheme has passed through the community, and we find we have all bought some of the stock. Living in a small country community, that old family doctor is just a little bit closer than anything else in the world. I have gone through the experience of sitting through the night with that man upon whom everything depended, my own choice—my family doctor. I now have three years and two months in which to be Governor of the State of Indiana. If there is one thing that will be to my credit when I finish, it will be that I never let that old country doctor down. That I promise you! And, as governor of the state, I am trying to remember that I am just a country boy.

As chief executive of the State of Indiana, I have no panacea—no cure for all the ills of Indiana or the nation. Anyone who thinks he has all the answers—the cures for everything that is wrong in the world—is mistaken. We are going through a period which requires cooperation and the best thinking of all the people of a great state like Indiana if we are to cure just part of the ills of our state.

I was happy to be preceded by my good friend, Dr. LaRue Carter, who is the chairman of Indiana's mental screening hospital board — a board which will have much to do with the future treatment of mental diseases in the great State of Indiana.

I might have come before you with a manuscript about all the things we are going to do for public health, but I am not going to do that this evening, because this is a group of people to whom I just want to talk.

In the last session of the legislature many things were done in the field of health. They didn't just happen—they were brought about. During the last forty-five days of the session the Majority Policy Committee met in my office every noon. We had sandwiches and coffee, and went over our program. We had sixteen health bills. There are one hundred members in the House and fifty in the Senate. That is one hundred fifty votes. On sixteen bills, that is a potential of twenty-four hundred votes. To the credit of our opponents, as well as the party in control, on those sixteen bills there were just twenty-three negative votes in both the House and the Senate. Why was I concerned about it all?

* Presented before the annual banquet of The Indiana State Medical Association, at French Lick, November 7, 1945.

Well, I discovered that Indiana stood thirty-eighth among the states of the Union in public health. It was high time someone be concerned about the great question of public health. Following the passage of these bills the question arose as to an administrator. I do not know how well you know Dr. L. E. Burney, the man we selected as secretary of your Board of Health, but to me the greatest recommendation is that he comes from Berne, Indiana, and is a graduate of our own Indiana medical school. He was in charge of the New Orleans district for the Federal Health Service of America. He is thirty-eight years old, and holds the rank of colonel. After careful investigation by some of the best minds of your group, it was decided that here was the man who could lead Indiana out of thirty-eighth position, and perhaps re-establish us in the place we held many years ago as Number One in the public health field. That was the thought behind all these bills. There is no more important subject in all Indiana than the health of the citizens of our state. There is much work to be done. We are still in the period of just starting some of these projects. Construction of our mental screening hospital will start quite soon. This will mean much in the treatment of mental cases in the State of Indiana. Within the next few days we will announce our Advisory Council on Health—twenty-five to forty individuals. We have sent out questionnaires and have received recommendations from the dental association, and from all of the other associations that are in any way interested in health. These recommendations will be followed in naming the membership of the Advisory Health Council.

I have been much concerned with the question of stream pollution, because I believe it has a direct bearing on the question of public health. Recently we brought back from the Army, Major B. A. Poole, sanitary engineer, who is working with our Department of Health. As I was writing letters to the various cities and towns, telling them that they must take care of the stream pollution problem, I suddenly received a letter saying that four of our twenty state institutions were throwing their pollution into the streams. So, even the State of Indiana was not without fault. We are trying to rectify that very important matter at the present time.

We took a forward step in the matter of inspecting and licensing of nursing homes. You have all been required to deal with these homes throughout the state, and we all know the menace they have created. There is much to be done in this field, but these homes are being inspected—they will be inspected—and they must be licensed after January first.

The establishment of the Department of Public Health in connection with our medical center is a further step forward. Your president mentioned the reorganization of the State Board of Health. Not only does this board now have representation by nurses, dentists, and other related groups, but the secretary of the State Board of Health, under the reorganization act, is selected by the board, and not by the governor of the state.

I was amazed, recently, to learn that of the five million dollars which we have invested in our medical center in buildings, only one million dollars was provided by legislative appropriation. The other four million dollars came from the public-spirited citizens of the State of Indiana, who generously contributed to make this splendid health center possible. I am happy tonight that the man who has guided us through the years, Doctor Gatch, is here with us. This wonderful center is a monument to Doctor Gatch.

In the field of scientific research it is vital that the control of atomic energy be utilized for good. If American science can devise the means of accomplishing this, I believe that we can provide the laboratories, the research, the personnel—teachers drawing proper salaries, and make the same advancement in the field of medicine. There can be no more important work than that done in research for the control of cancer, tuberculosis, infantile paralysis, and the many other diseases which are so prevalent. Of course, it will cost money, but what better reason is there for spending money than for increasing the facilities of our medical center, which is now recognized throughout the nation. I pledge that in the years to come we are going to do our best to further medical research and laboratories in connection with our schools of medicine, dentistry, and nursing which we now have at the fine medical center in Indianapolis.

I have spoken of the splendid work done by your group, not only in the Army and the Navy, but as civilian physicians. I know the hours you have given to mankind during these past four years. The State of Indiana is grateful to you for your part in the victories which we have won on all the battlefronts of the world. But it seems to me that the responsibility of citizenship rests more heavily on our shoulders now, with the conclusion of the war, than it did during the war. Indiana is proud of the record it has made. We were seventh in production of vital war materials among all the states of the nation. Neither our population nor our wealth justified that position, but Indiana stood seventh.

We stand second in reconversion among the states of the nation—reconversion to civilian production. This is a record of which we are justly proud. Indiana—the crossroads of the nation, one-half of our population industrial, one-half agricultural—occupies a unique position among the states of the nation. As civilians, we have a tremendous responsibility as we map the course of the future. During the war period we furnished the arms, not alone for the armed forces of America, but for our Allies. We have fed and clothed the men in our armed forces, our own civilian population, and the armed forces and civilian population of our Allies as well. Never in the history of the world has there been such a record of productivity. Then, in a few short weeks or months a paralysis overtakes Amer-

ica—a paralysis brought about through lack of understanding between labor and industry. I am optimistic about the solution of these problems. Certainly a nation capable of the great accomplishments which were ours during this war period is in a position to assume the leadership of the world.

Quite recently it was my privilege to speak on the Constitution. I believe that much of our greatness is due to the underlying principles of our government, laid down more than a century and a half ago. The liberties and freedoms guaranteed by the Bill of Rights helped make us a great nation. Here we have rule by the majority, and I say to you—and I know I have the cooperation of each and every one of you—that it shall always be a state in which the majority rules, and never a state or a nation where an unscrupulous minority can assert its will over that of the majority.

As we looked forward to this period in which our four hundred thousand boys and girls would be coming back to Indiana from service on all the battlefronts of the world, we established a Veterans' Affairs Commission. We have provided for the selection of a Veterans' Affairs officer in each county. Why? Because the boy coming back from the battlefront is entitled to the helping hand and the guidance of the people in his home community. He does not want someone from Pittsburgh or New York to come into his county and tell him what his rights are. He wants help from someone in his local community who understands his problems. If it is education he desires, some local committee should be in a position to sit with him and assist him in picking out his curriculum and the school he should attend. One month after the passage of the G.I. Bill of Rights there were fifty-four applications filed for colleges in the State of Indiana. Only two of those were granted. In other words, an effort was made to obtain this money from the Federal Government and still give nothing to the returning veteran. On the question of employment, there should be a special local committee whose job it is to see that the returning veteran receives employment comparable to the employment which he left when he entered the service. There is a tremendous opportunity for service by committees properly established on the local level. I served for years as Service Officer of my local American Legion Post. I know that these boys do not want someone just to advise; they want someone to help them prepare forms, affidavits, et cetera. Why am I talking about this? Because we build Indiana and the nation according to the attention and the guidance we give these boys and girls coming back from this war.

You and I have been privileged to lead a fine life. Our shores were not invaded. No bombs were dropped on our cities. We enjoyed a marvelous heritage from our forefathers. Are we, as civilians in this period, going to pass on that same heritage to our boys and girls who fought against dictatorship in this war? It is a challenge which goes beyond anything we may be interested in personally. The state can lead the way, but it is the good citizens of the state, like this group assembled here tonight, who must be relied upon to give that leadership back in the home community.

ABSTRACTS

SULFADIAZINE INEFFECTIVE IN EPIDEMIC

With the outbreak of a major epidemic at a large naval training center sulfadiazine was found no longer effective in the treatment of diseases due to streptococcus infection, such as scarlet fever, rheumatic fever and bronchopneumonia, according to a study appearing in the December 1 issue of *The Journal of the American Medical Association*.

Epidemiology Unit Number 22 of the Bureau of Medicine and Surgery, Navy Department, reported that "this was the first time at this center (Camp Hill) or in any other naval activity where sulfadiazine prophylaxis had proved ineffective in controlling streptococcic infection."

Although it became apparent during the study that increasing the dose of sulfadiazine was not effective in controlling this type of disease, the authors found evidence of the stimulating effect of sulfadiazine-resistant strains on streptococcic illness.

In conclusion the authors said that "there was some suggestive evidence but no definite proof that, in the presence of sulfadiazine-resistant strains, sulfadiazine prophylaxis tended to increase streptococcic infection, particularly scarlet fever."

BACTERIAL ENDOCARDITIS TREATED SUCCESSFULLY WITH PENICILLIN

Twenty patients with subacute bacterial endocarditis, a disease previously considered fatal, were treated with penicillin last year at the University of Pennsylvania Hospital, with the result that sixteen had definite subsidence of their infection. Of these twelve are still alive, eight having died of other complications according to a report in the November 24 issue of *The Journal of the American Medical Association*.

Harrison F. Flippin, M.D., Robert L. Mayock, M.D., Franklin D. Murphy, M.D., and Charles C. Wolferth, M.D., with the technical assistance of Majorie Wiley, Philadelphia, wrote that "we employed 300,000 units of penicillin a day for fourteen days as the initial course. This appeared adequate in fourteen of the twenty cases. However, in view of subsequent experience with sixteen additional cases of the disease, not included in this report, we believe that all patients with subacute bacterial endocarditis should receive at least 500,000 units a day for at least five weeks."

The penicillin was injected into the veins of the patients, but, according to the authors, there is no reason to believe that this method is superior to injections into the muscles.

Subacute bacterial endocarditis usually attacks valves of the heart that are already damaged. The germ which is responsible for the condition in 90 to 95 per cent of cases is the Streptococcus viridans, while the gonococcus and the influenza bacillus are the causes in 5 to 10 per cent.

Although only twelve patients lived, the authors wrote that "of the eight who did not survive four were completely free of active infection and died as a result of heart disease. Three patients in this group failed to respond to therapy, and the eighth died soon after treatment was completed as a result of an acute pulmonary embolus.

MEDICINE IN THE POSTWAR WORLD*

MORRIS FISHBEIN, M.D.

Editor, The Journal of the American Medical Association

CHICAGO

The science of medicine fortunately has not, like many another aspect of man's life, remained in status quo since 1940; neither has it regressed—at least here in the United States.

Reports that come from Europe tell of medical schools destroyed or closed for years; of libraries burned or with their contents disseminated; of hospitals shattered; and of dispensaries for the tuberculous closed, with their patients spreading tuberculosis in areas where sanitation and hygiene have lapsed. True, there have been no great epidemics even in Europe—nothing comparable to the epidemic of influenza that devastated the world in 1918, yet typhus has been a constant threat; diphtheria has become an acute and virulent disease in areas where it was formerly under complete control; the incidence and the death rates from tuberculosis have increased in Holland, in Denmark, and in France from two to three times, and malnutrition with its associated breaking down of resistance to infection is widespread. Finally, the wanton killing of great numbers of physicians for political reasons and the forcing out of thousands of well-trained doctors because they refused to concede the right of a foreign totalitarian government to dictate their activities have left European nations well nigh helpless before the threat of disease, almost incapable of meeting the challenge of a world again at peace and ready for rebuilding. These are some of the liabilities that now confront most of the nations of Europe. What is the situation here at home?

Long before Pearl Harbor, the American medical profession had begun to prepare for the conflict that already appeared inevitable. With the coming of the Selective Service Act, physicians were ready and volunteered in great numbers to meet the needs of the Army for physical examination and care of recruits. Almost 30,000 doctors gave freely of their time and efforts for the work of the Selective Service System. Then when the call came from the armed forces for physicians to meet their tremendous needs, doctors volunteered in adequate numbers. Some 60,000 physicians were commissioned in the Army and Navy Medical Departments and in the United States Public Health Service; some have been engaged in the activities of the Veterans Administration, and still others in the work of other governmental agencies.

MEDICAL EDUCATION AND THE SUPPLY OF PHYSICIANS

In 1940 there were about 180,000 physicians licensed to practice medicine in the United States. The first surveys made by the American Medical Association and those later undertaken by the Procurement and Assignment Service for Physicians, Dentists, Veterinarians and other medical personnel revealed that 160,000 were available for consideration as to military service. Thus, there remained for the care of our civilian population, for medical teaching, and for all of the other functions filled by physicians about one doctor to every 1,500 people. This, nevertheless, is far better than the conditions that prevailed in Great Britain, with one doctor to 2,400 people and those prevailing in other parts of the world with one doctor for as many as 6,000 or 7,000 people. Whereas we have in our Army, at worst, five doctors for 1,000 men, the Chinese army has been getting along in many places with one doctor for 10,000 men. Their medical service has been, for the most part, carried on by first aid assistants of their medical corps.

In order to meet the needs of our armed forces, young men who graduated in medicine from an accelerated curriculum during the war years have gone promptly, after a nine months' internship and, in a few instances, after an additional nine months' residency, directly into the services of the Army and the Navy. From 15,000 to 20,000 such young physicians are now with the armed forces. Eventually they will be returning home. Fortunately, for the American people, the replies to a questionnaire, circulated among the physicians of the armed forces, indicate that more than 85 per cent express a desire for additional medical education before they again take up the practice of medicine. Even under the best of circumstances, with full utilization of the four years allotted to an overcrowded curriculum, medical education is seldom complete. The practice of the past has demanded a minimum of one—preferably two years—of internship, with time allotted to medicine, surgery and obstetrics, and some time to all of the specialties. Most of the young men who wished to qualify for specialistic practice have added to this period from three to five years of additional training. This is the system of medical education which gave our armed forces physicians so well trained that they were able to save thousands of lives in service which otherwise would have been lost. American Medicine is proud of its standard of medical education—unquestionably the best in the world.

American Medicine looks forward in the postwar period to a restoration of the standards that prevailed before the war. Those standards demand adequate numbers of well-trained teachers. The medical schools, too, have contributed nobly to the armed forces. The teachers who were declared es-

* Presented before the Fort Wayne (Allen County) Medical Society, at Fort Wayne, on October 9, 1945.

sential and who remained at home have worked to the point of physical and mental exhaustion in an effort to maintain an adequate supply of physicians with the accelerated curriculum. There have been voices to urge a continuance of an accelerated curriculum in the postwar period; there have even been some who would depreciate the quality of medical education in order to produce greatly increased numbers of poorly-trained men. They have used the inadequate supply of medical care in some remote areas or in new industrial communities as the reason for their urging. Some pseudo-economists have felt that the production of vast numbers of physicians would force a revolution in the nature of the practice of medicine by making it necessary for physicians to accept government domination and complete control in order that they might be able to practice their professions. This is not intelligence; it is fanaticism. It is the same type of thinking that led Hitler, Goering, and Goebbels to attempt to destroy the civilized world, to prove the righteousness of their weird and disordered phantasies.

Before we entered the war, we had in the United States approximately one doctor for each 700 people—a greater concentration of physicians to population than existed anywhere else in the world. As men are discharged from the armed forces, we will begin again to approach that concentration, provided, however, that an intelligent government will recognize the need and make adequate provision for a supply of young men suitably educated in the premedical studies to meet the requirements of our medical schools. At this very moment our government has not recognized the danger to the public health that is inherent in an inadequate supply of students for schools of medicine. Unless Congress takes prompt action on the bills submitted by Senator Ellender, of Louisiana, or unless the Selective Service System exercises powers already granted to it under the Selective Service Act to defer men pursuing courses of premedical studies, we shall see, beginning in 1946, a diminishing medical profession at a time when medicine, not only in the United States but in all the world, is calling hungrily for well-trained men. Even by the most casual of estimates we shall require, continuously, for government agencies far greater numbers of physicians than were ever needed before. The most conservative estimates would indicate 5,000 physicians for the Army, 2,000 for the Navy, 5,000 for the Veterans Administration, 3,000 for the United States Public Health Service, and 3,000 for services in occupied areas abroad—a total of 18,000 physicians unavailable for the care of our civilian population.

The needs of American Medicine are being met by voluntary actions in the various states. To the sixty-nine Class-A medical schools which we now have in this country, there will, no doubt, shortly be added a school in Seattle, Washington; one in Birmingham, Alabama; and one in Utah. Discussions have already begun as to the possibility of creating new medical schools in Florida, the Dakotas, Maine, and Vermont. As the populations of various other states increase, and as the facilities for teaching medicine are improved, particularly by the construction of new hospitals, a continuous increase in the number of good medical schools and in their quality is likely to occur.

The quality of medicine and of medical service in any nation is primarily dependent on medical education, next perhaps on medical research, next on the number and quality of hospitals, and finally on the economic situation which controls the supply and the distribution of medical service. Recent discussions in the United States have placed far more emphasis on the last of these factors than on any of the others. All are, of course, closely interlocked in their functioning.

MEDICAL RESEARCH

American Medicine was in the very forefront of research at the time war threatened us. To meet the needs of the war, new mechanisms were developed for the speeding and intensification of research particularly related to military medical problems. The outstanding agency was the Division of Medical Sciences of the National Research Council, supplemented by the Committee on Medical Research of the Office of Scientific Research and Development. These agencies were able to mobilize and coordinate the activities of many hundreds of physicians recognized as leaders in medical research, and to utilize the services and facilities for research of all of our leading universities, medical schools, medical research institutes, and similar agencies. The development of atabrine as a substitute for quinine in the treatment of malaria, of DDT as an insect repellent, of the sulfonamides and penicillin for the control of innumerable infections, of blood plasma and the numerous by-products of the blood procurement program (such as gamma globulin, blood albumin, thrombin and fibrin foam), of new methods of treatment of ringworm, burns, and many other conditions, may be credited to these agencies. Through the Division of Medical Sciences, committees standardized the control of infections, the medical and surgical treatment of diseases and injuries, aided in the procurement of essential drugs and medical supplies, and did much to maintain a high quality of medical service under difficult conditions. Without the voluntary services of the physicians who participated wholly without remuneration and without the activities carried on by these voluntary agencies, the high quality of medical care continuously available to the American people during the war period might very well have been unavailable.

As a result of the knowledge gained by medical research and applied by the highly-trained product of American medical schools, malaria failed to destroy our armies. Whereas seventy per cent of men wounded in the abdomen in World War I died of their wounds, only twenty per cent of such wounded died during this war. Pneumonia, once a

devourer of young men in military service, had a death rate in the United States Army of a fraction of one per cent. Even the threat of tropical disease has been efficiently combatted by the creation of special schools in which the facts regarding such diseases are taught to medical officers who diagnose the condition in our troops, treat the cases successfully, and prevent the importation of cases (except those under full control) to our shores. We do not fear outbreaks of tropical diseases in the postwar period. New forms of virus infection, such as infectious hepatitis or jaundice, considered possible invaders, are being given special study. The state of medicine is never static. The living organisms—bacteria, viruses, animal parasites — constantly change in their virulence, and adapt themselves to new conditions of living. The frontiers of medicine move ever forward. The challenge to research, the medical explorer, is a constant call to action.

A few months before his death, President Roosevelt announced that he would shortly send to Congress a message regarding means by which the intensified productive research of the war period could be prolonged and extended into postwar times of peace. A committee headed by Vannevar Bush, aided by a number of subcommittees, has prepared a report, and it is in process of being placed in the hands of President Truman. He will, no doubt, shortly forward it to Congress with his own recommendations as to the type of legislation necessary to achieve this highly desirable objective. As I have indicated previously, the relationship between medical education, medical research, hospital facilities, and medical care is close and indissoluble. Each of the four knights is wholly dependent on the others for the success and advancement of the crusade against the four horsemen who ride with death for mankind in wartime. Any government program designed to meet these needs must recognize the relationship. There are many ways in which governments—federal, state, and local—may be helpful in achieving the objectives of these phases of medical activity, but the importance of sound, independent medical leadership cannot possibly be overlooked. With such leadership, medicine can promise progress—results of high quality, and economical operation. Without it there can only be waste, inefficiency, and inertia.

THE HOSPITALS

The rise of the hospital as the center of medical care in the United States is one of the marvels of American Medicine. These hospitals are a reflection of the advancement of medical science. Here are made available to ailing mankind the refinements of medical skill. Few hospitals were needed when medicine was almost wholly an art. Then, as invention and discovery made possible a prolongation of all of the senses of man used in the diagnosis and treatment of disease, the hospital became the place where varied and costly facilities could be assembled and made accessible to highly-trained specialists, expert in their use. At the center of the hospital sits the clinical pathologist, skilled in detecting the slighest variations in the tissues, secretions, and excretions of the body, in the presence of disease. Here sits also the roentgenologist, capable of making visible the changes in organs and structures concealed deep in the interior of the human organism. Here is the apparatus of physical therapy, applying physical forces such as light, heat, water and electricity, for their healing virtues. Here assemble the surgical teams—surgeon, anesthetist, nurse, and pathologist—to perform miracles of repair and reconstruction, inconceivable to scientists of a century ago. Here infants are born in an environment safe for mother and child. Here are modern methods of treatment, such as blood and blood plasma transfusion, intravenous injections, oxygen and helium inhalations, penicillin and sulfonamides, which reduce death rates to minimal percentages. Here the skills associated with the use of the innumerable diagnostic devices, such as the electrocardiograph, encephalograph, and basal metabolic apparatus are employed in the finest application of the art of detection. Here erudite investigators with philosophic and psychologic background plumb the depths of human thought, understanding, and emotion, to find the concealed psychic bases of somatic manifestations. In our great teaching hospitals the group practice of medicine is exemplified by a mastery of disease that is awe-inspiring in its efficiency.

Every proposal for the improvement of medical service in the postwar world includes the expansion of existing hospital facilities. With the war have come great shifts in our population. New methods of transportation have been developed on a vast scale. Truly, it may be said that a patient two hundred miles away from a good hospital today is closer than many an invalid was when only eight miles removed from such a hospital fifty years ago. Motor cars, airplanes, the telephone and the radio annihilate distance and overcome time.

We have come to learn that a hospital with less than a one-hundred bed capacity finds it difficult to function efficiently. We know that a minimum number of patients are necessary to provide sufficient responsibility to the pathologist, the roentgenologist, and the anesthetist to permit maintenance of the skills they have acquired by years of training. The costs of administration and medical service are lowered as costly apparatus and equipment are utilized by greater numbers of the sick. Nevertheless, there also comes a point in the growth of an institution when bigness becomes a handicap rather than a virtue. As institutions grow into the thousands of patients, there is an inevitable loss of contact between those at the top responsible for the care of the individual patient and the patient himself. If there is any single aphorism that has become established with hundreds of years of growth of modern medical science, it is the great significance of personal contact between the doctor and his patient, between the head of a great institution and the leaders of the various departments under his supervision.

For a while it seemed that the problems of medicine would be solved by the creation of great medical centers; such centers as Columbia and Cornell in New York City amazed medical visitors from abroad. Yet these institutions must be considered peculiar to the areas in which they have evolved, and certainly cannot be the answer to the problems of medical care for 135,000,000 people scattered in varying areas of population density over millions of square miles of diversified geography.

One of the most recent proposals has been an evolution in the growth of medical facilities, which would include in remote areas diagnostic and health centers in which would be available modern diagnostic facilities, personnel, and equipment necessary for the practice of preventive medicine in groups of people and for the education of the public as to health needs and health provisions. Such health centers would be correlated with community hospitals of not less than one hundred beds, and with outpatient departments at suitable intervals of space and time related to the density of the population and the ease of access. In association with medical schools in the larger cities would be hospitals of greater scope and specialized institutions for such specific medical problems as the practice of surgery of the brain and the nervous system, the utmost refinements of abdominal surgery, the solution of problems of psychiatry, and medical research.

The recently-introduced Hill-Burton Bill, which provides for an expansion of hospitals and health centers throughout the nation, is definitely pointed toward an evolution in this direction. It would seem to be a proper entrance into medical care by federal government, since it calls for study to determine an existent need before aid is given; local management; local control; local responsibility for the maintenance of such institutions as are constructed with federal funds; and management by a board of experts qualified to make decisions in problems of the character concerned.

EVOLUTION OF MEDICAL SERVICE

Every answer to the problem of a greater distribution of medical care in the United States includes the application of the insurance principle. However, many methods of application of this principle are already in effect in the United States which is, from the point of view of most types of insurance, the best insured nation in the world. If we have lagged in our application of the principle of insurance to the care of the sick, it has not been because of a lack of belief in the principle of insurance, but because American leaders in both the fields of insurance and medicine have not as yet had available the data or the experience upon which to erect a sound structure. The experience of foreign countries with governmental-controlled insurance against the costs of sickness has not been such as to inspire confidence in the ability to apply their technics to the American way of life. Inevitably, the application of this form of social security to the people of foreign nations has led to a depreciation of the factors essential to the maintenance of liberty and democracy. They have depreciated the individual while they exalted the state. They have destroyed initiative and enterprise, and yet at the same time have failed to provide for the majority of the people concerned as good a quality of medical care as has been, for the most part, available in this country.

Hence, we have turned in the United States toward voluntary systems of insurance against the hazards of illness, such as the Blue Cross Plans for hospitalization and the medical care plans developed by state and county medical societies, cooperative groups of industrial workers and agricultural workers, and systems developed by professional actuaries for private insurance companies. Today some 18,000,000 people in the United States are insured against the costs of hospitalization under the Blue Cross Plans, and well over 20,000,000 are covered in various degrees through the industries and cooperative groups with which they are associated. As increasing experience is gained with these technics, they improve constantly in extent and quality of the services they render and in a lowering of costs to the individual purchaser.

Many an economist or political leader unfamiliar with the special problems concerned in medical care argues that medicine proceeds too slowly in its study and application of these technics to the provision of medical care. Yet by that controlled scientific study, progress certainly is made toward a sound system that will meet the special needs of the American people. The loss of our democracy and our fundamental liberties is too great a price to pay even for such security as might be provided with a totalitarian system of social security. One inevitably reverts to a repetition of that fundamental truth voiced by Benjamin Franklin: "He who sacrifices liberty for security is likely to lose both." Exactly as we seem to be moving toward an acceptable technic for governmental aid in the development of such medical facilities as health centers and hospitals, so also may we move toward the development of suitable provisions for meeting the costs of medical care.

Many a proponent of revolution in the provision of medical service urges as a solution of our problem the establishment of groups of specialists in great medical centers remunerated by salaries to be fixed by some super-government, and with this the inevitable elimination of the general practitioner and the private practice of medicine. Here again the false "Gods of Economy," efficiency, and absolute control have caused the advocates of such systems to lose sight of humanity, sympathy, and the spirit of man. However, even their mathematics are at fault, since every scientific study has shown that 85 per cent of human disease is still satisfactorily diagnosed and treated by the competent general practitioner, trained under the system of medical education in this country, with the

amount of equipment that he can carry in his handbag or make available in his office. It is the remaining 15 per cent—the most advanced type of medical service—that makes necessary most of the systems of organized provision of medical facilities and technics for meeting medical costs.

In the United States the provision of preventive medicine has been of an exceedingly high order. The proof of the statement lies in the fact that we have the lowest sickness and death rates of any great nation in the world. Nevertheless, more than a thousand counties still lack full-time health officers. The abuse of medical statistics by writers of propaganda in the field of medical care has been one of the most appalling displays of false propaganda in the last decade. They repeatedly have cited figures for New Zealand, without revealing that those figures concerned only the white European population of New Zealand. They have cited the maternal mortality statistics of Sweden, without pointing out that the Swedes of Wisconsin and Minnesota have lower death rates for maternal mortality than the Swedes of Sweden. They have neglected to indicate that their citations of American sickness and death rates failed to emphasize such special factors as the syphilis of the Negro in the South, and the horrible mortality from tuberculosis among Negroes in the North, because of the failure of the North to provide adequate housing and suitable medical facilities for tuberculosis for the northern Negro population. Without a thorough comprehension of these factors, citation of medical statistics is the practice of fraud and chicanery by the economists and politicians who use these figures to secure unwarranted goals.

Probably the greatest abuse in the citation of statistics has related to the figures concerned with examinations of young men for the Selective Service. The announcement is broadly made that almost 50 per cent of the young men in America are unfit. They fail to say unfit for military service, and by a standard higher than has been established by any other nation in the world. The physical condition of American youth is not deplorable. True, there are great numbers of preventable and remediable defects which should be prevented as far as possible, and which should be remedied, but it should not be necessary to paint a picture of a tottering American youth, when anyone capable of reading newspaper headlines can find out what American youth has done on the battlefields of Europe and the Pacific, in the air and on the sea, and in foxholes everywhere. Let us use the scientific method in studying our problem, and by that method derive a scientific answer to our medical problems.

I would emphasize the scientific approach, always, in searching for solutions to the problems of our daily life. The basis of the scientific method is scientific study and analysis of the problem before attempting a remedy. It is scientific evaluation of the remedy by controlled tests before applying it on the individual patient. It is scientific evaluation of the remedy on a few patients before attempting its application to all of mankind. Young men and women who come from the finest institutes of medical education in the world have learned to apply the methods of science in problems definitely medical. They may well become the leaders of the postwar world by the application of similar methods of thought and action in the other aspects of life and living.

ABSTRACT

INFANTILE PARALYSIS VIRUS IS ACTIVE LONG BEFORE DETECTION

Buffalo, New York, and Chicago investigators found that there is a definite pattern to infantile paralysis and that actually an epidemic may start months before any paralytic cases are recognized, according to articles in the December 22 issue of *The Journal of the American Medical Association.*

The Buffalo authors, Martha L. Smith, M.D., Edward M. Bridge, M.D., Helen E. Underwood and Grace E. Dale, from the Department of Pediatrics of the University of Buffalo School of Medicine and the Statler Research Laboratories of the Children's Hospital of Buffalo, based their study on the origin of an epidemic which occurred in the Buffalo area in 1944.

They reported that "evidence has been accumulated which points to the conclusion that the disease was prevalent in the initial community long before the first case of paralysis was recognized. This evidence is based on studies of the illnesses among contacts, both direct and indirect, of the first three cases of paralysis and on a knowledge of the minor illnesses, many of which were undoubtedly caused by the virus of poliomyelitis, which occurred in the school population during the months preceding the outbreak."

In Chicago, two physicians, Albert E. Casey, Birmingham, Ala., and William I. Fishbein, Chicago, working under Herman N. Bundesen, M.D., President of the Chicago Board of Health and Chairman of the Epidemic Committee of the National Foundation for Infantile Paralysis, Inc., concluded after their study that:

1. Multiple cases of poliomyelitis in the family were the rule rather than the exception when there were other children from one and one-half to eight and one-half years of age in the home.

2. Poliomyelitis was found to be contagious perhaps to the degree of 90 per cent in the one and one-half to three and one-half year age group, but less infectious in the older groups.

3. There was no evidence that flies and other insects played a major role in the spread of the disease in the neighborhoods studied, once the disease had been introduced.

4. Only about one and one-half out of six instances of poliomyelitis would have been diagnosed as such, even under an alert public health reporting system, without an intensive neighborhood study. Illness in the other cases of poliomyelitis was so mild in most instances that a physician was not consulted.

5. Paralysis developed in about one case in six, and about two in six could be confirmed only by animal inoculations or by spinal fluid protein examination done two to seven weeks after onset.

OSTEOMYELITIS

Treatment by Radical Saucerization and Early Skin Grafting*

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Treatment of chronic bone and joint infection secondary to compound fractures has always been a difficult surgical problem. Despite chemotherapy, improved debridement technique, open-wound treatment and adequate immobilization, osteomyelitis and suppurative arthritis continues to be one of the major surgical problems of World War II. Study of the numerous cases of exogenous osteomyelitis that have returned to the hospitals of this country has brought about improved techniques of treatment that will probably be useful in civilian practice. A method is presented in this paper that is suitable for the treatment of osteomyelitis secondary to civilian accidents.

The infection has been considerably modified by recent therapeutic advances, and is in general more benign and better localized than those heretofore encountered. Elimination of the wound organisms sensitive to sulfonamides and penicillin accounts principally for this lowered virulence of the infectious process. Improved measures designed to increase general systemic resistance also is an important contribution. The prompt availability of an adequate supply of whole blood, plasma, and other parenteral and oral protein concentrates has aided in maintaining a nutritional and tissue-fluid status favorable to healing.

These factors which ameliorate the infection exist with a less advantageous mechanical wound status. Extensive shattering of bone commonly encountered in combat casualties makes accurate saucerization difficult. Foreign bodies are present in a high percentage of cases; non-union, mal-union and severe fracture deformities are often encountered. Massive loss of adjacent soft tissue predisposes to large avascular areas which decrease the local blood supply. Direct trauma to major nerves and blood vessels is often associated with the infected compound fracture, and frequently post-traumatic and thermal neurovascular changes further disturb the nutrition and function of the injured limb.

Surgeons are daily confronted with the task of converting these dirty suppurating bone infections into clean, dry, epithelialized wounds. Treatment has principally followed the well-established "closed plaster" Orr[1] technique. Healing with this method is often prolonged and results have not infrequently been disappointing. Repeated saucerization may be required in many cases due to the soft tissue scarring and poor wound vascularity. Despite careful application of the Orr principles, drainage frequently persists for many months, especially about joints and the diaphysis of the long bones. Secondary reconstructive surgery of skin, nerve, bone, or tendon is thus delayed, hospitalization is extended, and the inevitable sequellae which accompany prolonged immobilization and chronic draining wounds ensue.

Attempts at immediate or delayed closure following removal of infected bone have met with limited success. Because of the extensive soft tissue damage associated with the wounds, it is often impossible to obtain a satisfactory closure even with relaxing incisions or other local plastic procedures.

Since the infection is of low grade and delay in healing is due in great part to mechanical and vascular factors, it has seemed advisable to utilize a surgical technique which provides a clean, skin-covered wound soon after saucerization. This technique consists of early "skin dressing" by covering the saucerized defects with an autogenous, split-thickness skin graft. This concept of early skin coverage in osteomyelitis is not new.[2,3,4] It has been tried on occasions in the past, then generally abandoned. We believe that this failure can be attributed to inadequate technical considerations and to the fact that the benefit of new chemotherapeutic agents have only recently become available. The following report presents our technique** and the results obtained in the treatment of one hundred fifty cases of chronic exogenous osteomyelitis and one case of acute hematogenous osteomyelitis.

SELECTION OF CASES

Osteomyelitis of all major long bones is included in this series. Also included are cases involving the bones of the foot, exclusive of the phalanges. Flat bones which have been saucerized and skin grafted include the scapula and the ileum. Chronic suppurative arthritis of the wrist, elbow, shoulder, hip, knee and ankle joints have been similarly treated. The site of the disease has not been a determining factor in the selection of cases; only those cases

* Presented before the Delaware-Blackford County Medical Society, at Muncie, in May, 1945.

[1] Orr, H. W.: Treatment of Osteomyelitis and Other Infected Wounds by Drainage and Rest, *Nebraska M.J.*, **12**:222-224, (June) 1927 (and many subsequent papers).

** Much credit for the development of the technique as outlined is due Ernest M. Burgess, M.D., of Seattle, Washington.

[2] Lord, J. P.: A Case in Which a Large Bone Cavity was Healed by Means of Thiersch Grafts, *J.A.M.A.*, **38**:1433-1434 (May 31) 1902.

[3] Reid, Mont R.: The Use of Large Reverdin Grafts in the Healing of Chronic Osteomyelitis, *John Hopkins Hospital Bull.*, **33**:386-388, (Nov.) 1922.

[4] Armstrong, Basil, and Jarman, T. Francis: A Method of Dealing with Chronic Osteomyelitis by Saucerization Followed by Skin Grafting, *J. Bone & Joint Surg.*, **18**:387-396, 1936.

CHART I

STATISTICAL SUMMARY

One Hundred Fifty Cases of Osteomyelitis Treated by Radical Saucerization and Early Skin Graft

Site	Cases Healed 25 Days	50 Days	Failures	Totals
Foot	17	11	2	30
Tibia-Fibula	38	28	8	74
Femur	4	18	1	23
Ilium-Scapula	1	0	2	3
Radius-Ulna	4	1	0	5
Humerus	1	4	2	7
Shoulder	1	2	0	3
Elbow	0	2	0	2
Knee	0	3	0	3
	66	69	15	150

CHART II

BACTERIOLOGICAL FINDINGS

One Hundred Fifty Cases of Osteomyelitis

Organisms*	Healed	Failures	Total
Diphtheroids	21	2	23
Gram — Bacilli	68	9	77
Gram + Bacilli	4	1	5
Pyocyaneus	5	0	5
Staphylococcus	49	5	54
Streptococcus	2	0	2
			166**

* Quantitatively organisms varied from 0-1000,000/cc. of normal saline wound suspension. To date no definite correlation has been established between quantitative bacteria count and rate or degree of wound healing.

** Mixed infections with more than one predominant organism in sixteen cases.

have been considered unsuitable in which skin grafting was mechanically impossible from an anatomical standpoint. The latter group comprises about 15 per cent of all cases of osteomyelitis under our care.

All cases showed radiographic evidence of bone infection. One hundred forty-four of the one hundred fifty patients gave a history of wound suppuration for a period of three months or longer, one patient's wounds having drained continuously for three and one-half years. In the course of this work we have surgically cleansed and skin grafted many soft tissue wounds; these cases are not considered in the scope of this paper. In this report we consider only lesions with definite bone involvement.

The bacterial flora of the wound has not been of prime import. All wounds were cultured in order to identify and estimate quantitatively the bacteria present prior to skin graft surgery. The results of these bacteriological studies appear elsewhere in this report (See Chart No. II).

We have placed considerable emphasis on the general health of the patient. Weight, temperature, pulse, and general sense of well-being were evaluated. The hematologic picture and serum protein levels, including the albumin-globulin ratio, were used as indices of the optimum time for surgery. No patient is submitted to surgery whose hemoglobin is below 13 grams.

In addition to the general measures outlined, each patient received an intramuscular course of penicillin and an oral course of sulfadiazine, starting four days prior to the saucerization and continuing until the sixth day after skin grafting. An occasional patient sensitive to either or both of these drugs received no chemotherapy. As experience with the technique has accumulated, a greater degree of importance is being placed on the surgical procedure rather than the chemotherapy. We have also gained the clinical impression that either of the two drugs alone, preferably penicillin, offers all the protection that is obtained with their combined use.

SAUCERIZATION

With this technique surgical removal of infected bone must be radical. The draining wound is excised widely consistent with its anatomical location and the conservation of vital and uninfected tissue. Subperiosteal stripping is avoided. The infected area is saucerized, removing obvious sequestra and adjacent involved bone. Care is taken to preserve continuity of the bone, particularly where fractures have united, but the operation, as its name implies, is a saucerization of both bone and scar, not merely a sequestrectomy. Throughout the procedure the operator is attentive to the mechanical status of the wound, cognizant of the fact that the defect created must be covered with skin. Depth is not a hazard to the technique. We have successfully skin grafted wounds that descend four or more inches through soft tissues to a bony base. It is imperative, however, that overhanging edges, crevices, small pencil-like tracts and sharp angles be avoided. If the process involves the shaft of a long bone and a plug of intramedullary scar has formed a barrier to extension of the disease, it is not advisable to remove this scar-tissue plug completely. Such removal may create a defect which is mechanically unsatisfactory for the reception of the skin graft. The scar is resected back until it is clean to inspection, then adjacent bone is prepared as directed above. It is desirable to remove all scar tissue adjacent to the infected bone when sacrifice of this scar does not expose major nerves, tendons, or blood vessels. The less the residual scar, the more vascular the wound and the more prompt the healing. Where two or more sinuses lead to a single area of bone involvement, the more mechanically-advantageous wound is saucerized and the remaining tracts cleansed conservatively, leaving them to close spontaneously.

In the management of involved joint surfaces all residual cartilage is removed, exposing bleeding, healthy, subchondral bone. Clinically viable cortical bone from which periosteum and soft tissue have



FIGURE I.

R.A.—Preoperative Radiographs.

been removed may be drilled to stimulate surface vascularity. More often we merely remove a portion of the external cortex with a sharp osteotome. Even though the remaining osseous base is dense, with correct operative timing, this bone will receive and nourish a skin dressing. In suitable extremity cases the saucerization is performed under pneumatic tourniquet hemostasis. Careful inspection of unstained tissues has proved to be a reliable guide for delineation of diseased tissues, and the usual staining agents are unnecessary.

After saucerization is complete the wound is thoroughly irrigated with sterile saline and packed open. Petroleum and other impregnated gauze is not used. The wound is lined with strips of muslin moistened in saline against which gauze fluffs or mechanic's waste is snugly packed. Proper wound packing is important. Gentle, firm pressure controls wound edema, improves circulation of the wound surface, and minimizes exudation from newly-formed granulation tissue. The operation is concluded by adequately immobilizing the part in a circular plaster cast incorporating adjacent joints.

POST-SAUCERIZATION CARE

Following surgery the extremity is kept elevated continuously and routine orthopedic care administered. An occasional case will bleed postoperatively to a degree requiring additional pressure. In this event a window is cut in the cast over the wound and the packing reinforced with additional pressure. It is inadvisable to remove the dressings and attempt to ligate bleeding points since the bleeding is generalized and can be controlled only by pressure.

On the seventh postoperative day the cast is bivalved. Under strict sterile precautions the packing is gently removed without anesthesia and the wound inspected. Cultures are taken to determine both the type of organism present and the number of bacteria per unit area of wound surface. If the saucerization has been successful the wound will present a comparatively healthly appearance; thin, vascular granulation having grown over its surfaces. Based on the clinical appearance of the wound, the surgeon now decides whether or not it will accept the skin dressing. Most cases (88 per cent of those reported in this series) are suitable for immediate skin coverage. Accordingly, sterile, dry, fluff gauze is again packed into the wound and the bivalved cast is strapped back in place. Skin graft surgery is performed the following morning.

As previously mentioned, we have been impressed with the importance of surgical timing. Too early application of the skin graft results in the death of the transplant because of inadequate vascularity of the bony base. If the delay is too long, a heavy overgrowth of dense, edematous, superficially-infected granulation tissue will likewise imperil the skin "take." We have grafted representative cases at varying periods from the time of saucerization to more than six weeks' post-saucerization. We are convinced that the optimum time zone for success is relatively narrow; in the vast majority of cases it falls sometime between the sixth and eleventh day following bone surgery. At the time of surgery it is well for the operator to estimate the day on which he believes the wound will be ready for skin grafting; thereby error in timing can be minimized and the wound will not be unpacked too early. The original pressure packing applied at the time of saucerization is an important adjunct in stimulating a proper granulation base. When it has been removed several days before skin grafting and a less effective dressing substituted, the rapid growth and weeping of the granulation following release of pressure results in progressive deterioration of the wound. Unless definite contraindications supervene, the skin graft is applied the day following the removal of the saucerization dressings. The presence of bare cortical bone, a grossly-infected necrotic wound or a definitely unsatisfactory bacteriological report constitute an unfavorable local wound status and necessitate further surgical or conservative wound treatment before application of the skin graft.

THE SKIN GRAFTING OPERATION

Routinely, on the eighth post-saucerization day, one day following inspection of the wound, the skin

FIGURE II.



R.A.—Osteomyelitis, tibia and femur, eight months' duration.

FIGURE III.



R.A.—Twenty-five days after saucerization skin graft surgery.

graft is applied. In contrast to the usual skin graft surgery, the recipient site in these cases often assumes bizarre and difficult mechanical patterns. Practically all wounds are three-dimensional, often to a depth extending almost through an extremity. The technique we utilize has been evolved by trial and error. Once a particular operative phase has been considered satisfactory, it has been adhered to rigidly. By this means we have been able to control and evaluate the technique. While we are still modifying the various operative phases, the steps which follow represent our current standard procedure.

The bivalved cast is removed at the time of surgery, exposing the operative site. Occasionally it is necessary to operate through a windowed cast in an effort to provide fixed support for an extremity. Packing is removed and the skin surrounding the saucerized defect is prepared. No antiseptic is placed in the wound. No tourniquet is used on extremities. The donor site, having been shaved and washed thoroughly with soap and water the previous evening, is now surgically prepared with ether, followed by an alcohol rinse. The site for skin removal will depend on the location and the size of the defect to be grafted. Thigh, abdomen, back, and chest skin may be used.

Having previously estimated the approximate quantity of skin needed, the operator removes it with a Padgett-Hood[5,6] dermatome. The donor site is then covered with one layer of boric acid ointment gauze and dry dressings. Care is taken not to cross-contaminate the two operative sites. The skin graft is routinely 0.018 inches in thickness, but it may be advisable to vary the thickness occasionally. Generally speaking, the less favorable the recipient site, the thinner the graft applied. We do not, however, use grafts less than 0.014 inches thick. Next, the operator exposes and prepares the saucerized defect. With a scalpel the entire surface of the wound is lightly revised, removing grayish slough, blood clot, and other necrotic material. The skin graft is then placed over the wound and accurately tailored to cover the defect without tension. Sometimes considerable ingenuity is required. Removal of a wedge of the skin graft, trimming of the margins, and repeated shaping of the graft to the wound are carried out until an accurate fit is accomplished. With a little experience one learns to estimate quickly the shape and size of graft required for each defect. Early in the development of this technique we moulded our grafts over dental cement or paraffin which had been placed in the wound and then removed after hardening. That technique has been discarded, as we feel that accurate tailoring of the graft can be accomplished by direct application to the wound without the use of an intermediate mold.

The graft is held in place with interrupted, nonabsorbable sutures. Sutureless techniques for fixation of the graft have not been tried as yet. We believe that the mechanical difficulties presented by irregular and deep wounds require the use of sutures. A single layer of boric acid ointment gauze is then placed over the graft and the wound carefully packed with mechanic's waste. One of the most important steps in the entire procedure is the proper packing of the wound. Accurate, firm pressure must be maintained; this feature cannot be overemphasized. Upon completing the packing, dry dressings are placed over the mechanic's waste and an Ace bandage snugly applied. Experience dictates the degree of final pressure necessary, but in general the dressings and Ace bandages should be as tight as the circulation distal to the operative site will tolerate. The part is then replaced in the bivalved cast, a pressure dressing applied to the donor site, and the patient returned to his ward. Operating time for skin grafting varies from thirty minutes to one and one-half hours, depending upon the site and size of the recipient area.

Despite trial of a number of pressure methods, the use of fine-textured, moistened mechanic's waste has proved to be most successful in our hands.

FIGURE IV.



F.S.—Preoperative radiographs.

[5] Padgett, E. C.: Calibrated Intermediate Skin Grafts, *Surg., Gynec. and Obst.*, **69**:779-793, (Dec.) 1939.

[6] Padgett, E. C.: Skin Grafting and "Three-Quarters" Thickness Grafts for Prevention and Correction of Cicatricial Formation, *Ann Surg.*, **113**:1034-1049, (June) 1941.

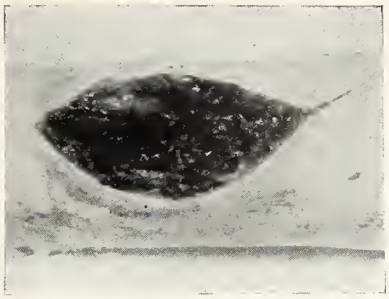


FIGURE V.

F.S.— Hematogenous osteomyelitis, tibia, seven weeks' duration



FIGURE VI.

F.S.—Twenty-five days after saucerization skin graft surgery.

Dental mold, sponge rubber or other agents may be used if the operator has a particular preference, but we believe that use of mechanic's waste affords the least number of possible technical pitfalls.

POST SKIN-GRAFTING CARE

Since wound pressure is an integral part of the treatment, it is imperative that extremities be continuously elevated and frequently observed, thereby avoiding circulatory embarrassment. Care is otherwise of a routine nature, the penicillin and sulfonamide medication being continued unless contraindicated.

The bivalved cast, dressing, and packing are removed on the sixth postoperative day. The graft is then left exposed to the air. Local treatment of the grafted area consists of a heat lamp two or three times daily if the graft is moist. Cleansing of crusts and other local measures which stimulate healing are used when indicated. Sutures are removed on the eighth postoperative day. Care is taken not to alter the circulation of the extremity during the early weeks of healing. Patients are allowed up for only short periods of time, and moderate elevation is continued during recumbency. Orthopedic measures such as immobilization, traction, and physiotherapy are continued where necessary.

For the first two or three weeks after removal of dressings the grafted area may blister moderately and occasionally become moist in areas over its surface. We have arbitrarily selected the twenty-fifth day as the earliest date to accurately evaluate the success of the operation. On the fiftieth postoperative day the wounds are re-evaluated. Wounds that are not completely dry, healed, and covered with skin by that time are considered failures even though a number will subsequently progress to complete healing.

RESULTS

Sixty-six of the one hundred fifty cases here reported presented healed, dry, clean wounds covered with healthy skin on the twenty-fifth day following the application of the skin graft (See Chart No. 1). An additional sixty-nine cases were completely healed fifty days after surgery. The remaining fifteen cases were rated as failures and required further surgery or more time to eliminate drainage.

The healed cases, many followed for several months, have shown little tendency to break down and suppurate. In an occasional case in which the saucerization was not thorough, devitalized bone has gone ahead to sequestrate and has required removal before the wound would heal permanently. With these few exceptions none of the cases presented any extension of the process following either of the operative procedures. In practically every instance the temperature and pulse were normal on the third or fourth postoperative day. In a number of patients the "skin dressing" was removed surgically several weeks or months after healing to permit application of a full-thickness graft or other necessary definitive local plastic surgery. As yet many of the cases have not required further plastic work. For this latter group of cases additional time and observation will determine the capacity of the grafted area to withstand normal wear and tear. In the sites where friction and trauma are not significant and motion is not excessive we are optimistic about the permanence of skin healing.

A number of interesting developments have been observed following the use of this method. Bone healing, delayed and faulty for many months, will frequently improve dramatically under the skin graft. Five of these cases with well-established non-union progressed promptly to union after saucerization and skin grafting. In practically every case radiographs revealed improvement in nutrition and quality of bone texture soon after healing of the skin graft. The soft tissue responded equally as well as resection of the scar, and elimination of suppuration resulted in improved local blood supply. Soft tissue fills in rapidly under the skin graft, thus decreasing the size of the original defect.

By far the most gratifying consequence has been the constitutional improvement of these patients. Rapid conversion of these dirty, malodorous, debilitating wounds into clean healed areas produces a remarkable physical and mental change. Weight, appetite, and blood findings reflect this fact. One has but to walk through the "old" and "new" osteomyelitis wards to appreciate the difference.

One case of acute hematogenous osteomyelitis, not included statistically in the one hundred fifty cases reported in Chart No. I, has been treated

with this method. The remarkable clinical course of this patient is recorded with his illustrations.

It is our desire that this report be considered a preliminary study. One earlier report on the use of this technique showed similar statistics, but full evaluation of this technique must await further observation.

CONCLUSIONS

With the method presented, suitable cases of chronic suppurative osteomyelitis can be successfully treated by radical saucerization and early skin graft coverage. Our experience with the technique is reviewed in a consecutive series of one hundred fifty cases of chronic exogenous osteomyelitis and one case of hematogenous osteomyelitis.

Management of chronic bone and joint infection by this means permits rapid elimination of draining, open wounds in cases which with ordinary methods of treatment frequently present a difficult, prolonged, and discouraging course. The degree of success achieved by the saucerization and skin graft technique justifies its continued application.

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THE RELATION BETWEEN TRAUMA AND MALIGNANT DISEASE

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INDIANAPOLIS

The question of the relationship between trauma and malignant disease is one that is frequently the subject of litigation in the courts and before industrial boards. Frequently large damages or awards are given to the patient or to his dependents which are entirely unjustified, largely because of the mistaken ideas regarding the nature of malignancy, ideas derived generally from erroneously preconceived notions and folklore.

For generations it has been an almost universal belief that cancer was the result of a bruise or some form of injury, and at the present time many victims of this disease, together with their physicians, still hold the same idea. The term "cancer" has for years carried a certain degree of stigma, and persons suffering from this disease have been loath to admit that it arose spontaneously from their own bodies. Instead, they prefer to blame its occurrence on some extrinsic cause, in most cases an injury, no matter how trivial. Such an erroneous belief in the traumatic etiology of malignant disease is in most cases of no serious moment, but in those cases in which malignant tumors are alleged to be due to trauma, and damages or compensation are claimed, great injustice may be done.

The following is a summary of the facts relating to the influence of trauma upon the causation and the aggravation of malignant disease. None of these statements is original, but they are taken from the statements of authorities on this subject, whose conclusions have been published during the past few years.

Until recently we have had to plead complete ignorance regarding the cause of malignant disease, but, thanks to the enormous amount of research on this subject, we are beginning to see light on many phases of this disease. There is yet much to be learned, but to date we have established certain definite facts which are pointing the way to a more complete understanding of this subject. At present we can state that the incidence of malignant disease is influenced by two factors: the first one is something within the individual that makes him susceptible to malignancy, such as some hereditary tendency, a congenital defect, or misplaced or aberrant congenital tissue; or second, some factor that makes his tissues a suitable soil in which the second or exciting factors can take root. These second, or exciting factors, are of two kinds, physical and chemical.

The physical agents which may produce malignant disease are x-rays, emanations from radium and radioactive substances, such as radium-bearing ore and mesothorium, and the actinic rays from the sun. As a rule, in the case of malignant disease resulting from the excessive application of or exposure to these physical agencies, there is no doubt as to the etiology of the growth.

The chemical substances that may excite malignant diseases are many, and these may be divided into two groups: first, those that arise within the body itself, substances whose exact nature is not definitely determined, but which, from clinical experience, we know exist; and second, those chemicals which exert their influence from the outside, substances whose composition we definitely know, and by which deliberate application to experimental animals or their accidental contact with human beings can excite malignant changes.

Those of the first group, the endogenous chemicals that may stimulate malignant changes, are abnormal substances formed in the body secondary to some abnormal or pathological process. It has long been observed that cancer may form at the site of a chronic ulcer; about the opening of a chronic discharging sinus; from oft-repeated lacerations of the mucous membrane of the mouth or

tongue from sharp or jagged teeth; from chronic eczema; from extensive scars, secondary to burns, that tend to ulcerate or become fissured; from Paget's disease of the nipple; and from ulcerating granulomas, secondary to syphilis or tuberculosis. The same is often true in chronic inflammation of the mucous membrane of the uterus, stomach, urinary passages, and gallbladder. The cause of the malignant changes which occur in these chronically-inflamed or ulcerated areas is most probably the result of the action of an abnormal chemical substance produced at these sites. There is no doubt that the excretions from these raw or inflamed surfaces differ chemically from the normal body fluids: moreover, such areas are always infected with some form of organism. There is reason to believe that these abnormal excretions are further modified by bacterial action which produces carcinogenic substances.

Other intrinsic chemicals that may be the exciting cause of malignant growths are the hormones and some of the secretory products of the glands of internal secretion. Experiments have been made in which cocks were injected with a testicular hormone that greatly increased sexual activity. The result of these experiments showed that these cocks had a very large incidence of malignant disease of the testicle. Excessive or abnormal internal secretion from tumors of the parathyroid glands has resulted in multiple giant-cell tumors of bone, and upon removing the parathyroid tumors the bone tumors have receded.

In many cases cancer of the breast is preceded by a chronic, cystic mastitis, a condition which is practically always bilateral. This cystic disease is due to an endocrine disturbance, most probably an altered internal secretion of the ovaries and pituitary gland. Long-standing stagnation is most likely a contributing factor. Inasmuch as chronic cystic mastitis is prone to undergo malignant changes, there are many reasons to believe that a continuation of the action of altered ovarian secretion, especially as occurs during the menopause, is the exciting cause of breast malignancy. During the past few years certain estrogenic drugs, the products of the glands of internal secretion, have been extensively administered for the relief of the symptoms of the menopause, and it has been reported that an unusual number of these patients have developed cancer of the breast. These reports, coming from several sources, give added credence to the assumption that breast cancer is produced by an intrinsic chemical excitant.

It has been observed during the past few years that quite a large number of cases of cancer of the prostate, even when complicated with bony metastasis, apparently have been completely cured by the removal of the testicles. This strongly suggests that after a certain age the testicular hormone possesses carcinogenic properties that act directly upon the prostatic tissues.

In the second, or extrinsic, group of chemical substances that are known to produce malignancy, certain coal-tar products head the list. The chimney-sweep's scrotal cancer has been recognized for many years. Some of the lubricating oils contain substances that definitely produce cancer in certain persons. This is unusual in this country, but is quite common in England. Another chemical met with in industry that may excite malignant changes is chrome-ore dust, which may be inhaled by miners and handlers of chrome ore and may result in cancer of the lungs. The increased incidence of bladder tumors, both benign and malignant, occurring in aniline workers, is most suggestive that aniline, and perhaps some of its derivatives, are carcinogenic substances. In all, forty-five chemicals have been determined as carcinogenic agents, both in man and in experimental animals.

While at the present time there is abundant evidence that malignant disease is excited by various forms of chemical substances when acting upon a suitable host, on the other hand there is no conclusive scientific evidence that malignancy results from a single trauma. Innumerable experiments in which trauma of various kinds has been inflicted upon animals have so far failed to produce any form of malignant growth. From the standpoint of probability, there is little or no reason to blame trauma as the cause of cancer and sarcoma. The New York State Compensation Bureau reported that out of 26,389 injured persons, 37 developed malignant tumors, a percentage about normal for a similar number of uninjured persons.[1] It has been repeatedly noted that there was a very low incidence of malignant disease in men injured in the first World War.

Bone sarcoma, often allegedly caused by trauma, is a common cause of litigation, and in most of these cases the injury consists of a bruise, generally so insignificant as not to be disabling at the time. The most severe injury that can occur to a bone is a fracture, yet claims of sarcoma following fractures are practically unknown. It is true that a pathological fracture may occur in a bone affected by sarcoma, but in such a case the malignancy preceded the fracture. Again, in many of the claims for alleged traumatic sarcoma of the bone the growth arises from the tissues in the medullary cavity of the bone, tissues that are perfectly protected by the bone cortex. It is inconceivable that any form of injury to bones, short of fracture, could in any way affect the bone marrow.

It can be readily understood why many patients, not understanding the nature of their trouble, might believe that their cancer was of traumatic origin. Malignant tumors occurring over the surface of the body may have been growing for a period of months without being noticed, until a swelling is found. During that period of time the patient may have received many bruises, contusions, and lacerations of more or less severity. If a swelling appears later, it is very easy for the patient to remember some injury that had occurred

[1] Ewing, James: *Neoplastic Diseases*—W. B. Saunders Co., Philadelphia, 1940.

in the vicinity of this growth, and the more he considers the matter the nearer, in his own mind, do the site of the injury and the growth coincide. Most persons are lax in examining their own bodies, so that a surface swelling may progress to a fair size before being recognized. It is quite common for a person, on examining an injured part or area, to first recognize a pre-existing tumor. This is true in most cases of the alleged traumatic breast cancers. Mistakes may be made even on microscopic examination of tissue removed from a persistent swelling following a trauma. It is well known that extravasated blood may cause a proliferation of mesoblastic tissue, and the microscopic picture at times may be difficult to differentiate from a true neoplasm. These partially-organized collections of blood most commonly occur about the periosteum, the scrotum and cord, the omentum, and the pia mater. Excessive callus and areas of traumatic myositis may, on gross examination, give the erroneous impression of a neoplasm.

A fairly common swelling occurring beneath the skin of the palms and soles is the traumatic dermoid or epithelial pearl. This results from a puncture wound in which particles of surface epithelium have been driven beneath the surface and continue to grow, forming a pearl-like tumor. Such a condition is a traumatic new growth of cells, but it is not a true malignant neoplasm.

There is one form of wound that may develop into a skin cancer. This is a wound that has been contaminated with a carcinogenic substance. For example, a carcinoma of the skin has resulted from a burn from hot tar. In such cases we have a definite carcinogenic substance, acting as the exciting agent, causing the malignancy. In all cases of skin cancer of alleged traumatic origin one should consider the possibility of a long exposure to tar, oils, or other carcinogenic chemicals. Whether or not the patient has ingested arsenic over a period of time should also be investigated.

As mentioned above, a malignant growth may appear at the site of a discharging sinus or chronic ulceration, being excited by the prolonged action of the local secretion. If in such a case the sinus or ulcer was due to trauma, a resulting malignancy must be considered as being due primarily to that trauma.

To sum up the above, we can state that the accumulative evidence to date points to the cause of malignant disease as being either a physical radiation or an intrinsic or extrinsic chemical substance, and there is no scientific evidence that malignant disease is ever caused by a single trauma.

THE AGGRAVATION OF PRE-EXISTING MALIGNANT TUMORS BY TRAUMA

It is often claimed that trauma to a malignant growth will cause it to grow more rapidly, or cause a more widespread and rapid metastasis than would have occurred otherwise. In order to understand why this is a mistaken assumption, it will be well to recall the nature of these growths. All forms of malignant tumors are composed of tissue cells, which are quite similar to the normal body cells. Throughout the normal life process many cells are constantly degenerating and being replaced by new and similar cells. Under normal conditions these new cells are formed and take their place in an orderly manner. In the case of a malignant tumor, certain body cells start growing rapidly and in an abnormal manner, with no respect to law and order. However, these tumor cells are more vulnerable to various influences than are normal cells. This is the basis of the treatment of malignant disease by x-ray and radium. These rays, when applied for treatment, fall upon normal as well as malignant cells, but the latter, being less resistant, degenerate, leaving the adjacent normal cells practically unaffected. It has been observed that patients suffering from malignant disease, especially sarcoma, and who also suffer a severe infection or a prolonged high fever, will show a reduction in the size of the tumor. It is well known that cutting off part of the blood supply of a malignant tumor will retard its growth. We can assume that when such a tumor is contused or bruised, causing a rupture of some of its blood vessels, the result will be a diminished circulation, with a greater probability of recession rather than aggravation of the growth. Experiments have been made on carcinomatous rats in which their tumors were severely crushed and no acceleration in the growths were noted. In fact, in many cases there was a retardation of the growth.

It has been claimed that a severe injury to a person suffering from a malignant tumor, even when the trauma is far removed from the site of the tumor, may hasten the malignant growth, due to the lowering of the general bodily resistance. This assumption is incorrect, because any lowering of the body resistance will tend to retard the growth of the tumor cells, owing to their relative vulnerability, as mentioned above.

Regarding the possibility of increasing or hastening metastasis by an injury to a pre-existing malignancy, it is believed that this will not occur for the following reason: any trauma to or about a malignant growth, sufficient to disrupt any of the tissues, will necessarily rupture blood or lymphatic vessels about this tumor. These vessels serve as the portals through which metastasis takes place, so by reducing the number of these portals metastasis will be retarded rather than increased. Moreover, the swelling about the tumor incident to trauma, which is generally extravasated blood or lymph, will tend to press upon the lymph and blood vessels, retarding metastasis.

While we hold that trauma neither causes nor aggravates malignant tumors; nevertheless, an injury to a pre-existing tumor may result in serious consequences, such as increased disability or even death. A large sloughing, superficial cancer may be lacerated or contused, causing a fatal hemorrhage; a blow over the abdomen may rupture a

hollow viscus afflicted with malignancy and produce a fatal hemorrhage or peritonitis; a severe blow to the head of a patient suffering from a brain tumor may cause an acute exacerbation, or death from acute brain edema or hemorrhage. While trauma does not actually aggravate the tumor growth in such cases, it does disrupt tumor tissue, and any subsequent complications must be ascribed to the trauma.

To sum up the above, we can conclude that with the present state of our knowledge, malignant disease is most probably the result of some form of carcinogenic substance, either arising within the body or applied from the outside. There is absolutely no evidence that a malignant tumor arises from a single trauma. On the other hand, trauma may result in a chronic discharging sinus or chronic ulceration, which eventually may be the site of a malignant growth. In such a case the trauma alone is not the cause of the growth, but the trauma produced certain changes in the tissues, which in turn produced certain chemicals, or endogenous carcinogenic substances, which are the real cause of the growth.

LUNG ABSCESS*

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The successful treatment of lung abscess depends upon the early recognition of the lesion as a separate disease entity. After this diagnosis is made adequate drainage is a prerequisite to early recovery. Conservative therapy has often delayed adequate drainage of abscesses which should have been treated earlier with more radical procedures. The customary therapeutic period of waiting for the patient to evacuate an acute, simple abscess may be palliative, but dangerous. It transforms the abscess into a chronic and often a complicated one, which reduces the chance of getting the patient well. An acute abscess can be complicated, of course, and a chronic one simple, but on the whole the time element is significant. In this series of fifty cases only ten were treated during the acute stage, or the first two months. In the ten the mortality rate was nil. All of the deaths occurred in the chronic group of forty cases, which were treated conservatively during the acute period.

CLASSIFICATION

The classification of the different types of lung abscess is a relative one, because one type may develop into another, especially if it is untreated. Lung abscesses have been classified according to age, etiology, bacterial contents, and the amount of pathological involvement. Clinically, lung abscesses may be called either acute or chronic, depending upon the age of the lesion. In this series the earliest abscess was seen three weeks after the onset of symptoms, and the oldest one after two years' duration. All abscesses which existed within a two-month period were classified as acute, while those over two months were diagnosed as chronic. The division of abscess on the basis of duration of symptoms is at best somewhat inaccurate, because it is difficult to say when an acute stage changes to chronic. Hence, none of the fifty were classified as subacute, because the transition period from acute to subacute to chronic is certainly more insidious and difficult to analyze than acute to chronic. All abscesses herein reported were putrid ones, as distinguished from non-putrid abscesses, by the presence of fetid odor. Neuhof and Touroff[1] differentiate non-putrid and putrid pulmonary abscesses pathologically. They state that a putrid abscess begins as an area of bronchopneumonia, which is more extensive and diffuse than in non-putrid ones. In putrid abscesses anaerobic organisms dominate the bacterial flora, while aerobic organisms predominate in a non-putrid abscess. Adequate drainage of the abscess may change the bacterial flora from anaerobic to aerobic and vice versa if drainage is delayed. Jackson and Judd[2] studied the aspirated secretions from the bronchi of one hundred fifteen patients. They summarized that both anaerobic and aerobic cultures show hemolytic staphylococcus, nonhemolytic streptococcus, hemolytic streptococcus, pneumococcus, or N. catarrhalis. Nonhemolytic streptococcus, anaerobic staphylococcus and streptococcus, spirochetes and fusiform bacilli are typical anaerobic findings. Anaerobic bacteria normally exist in the upper respiratory tract and become pathogenic in a favorable environment.

The majority of abscesses started as simple, or uncomplicated ones, but became complicated with varying degrees of pneumonitis, suppuration, necrosis, bronchiectasis, and fibrosis. Some investigators use the terms simple, or uncomplicated, and complicated to denote the amount of pathological involvement, while others use the term complicated to denote clinical complications. In this report we

* Read before the Vanderburgh County Medical Society, at Evansville, October 9, 1945.

[1] Neuhof, H., and Touroff, A. S. W.: Acute Putrid Abscess of the Lung, *Surg. Gynec. and Obst.*, **63**:353-368, 1936.

[2] Jackson, Chevalier L., and Judd, A. R.: The Role of Bronchoscopy in the Treatment of Pulmonary Abscess, *J. of Thoracic Surg.*, **10**:179, 1940.

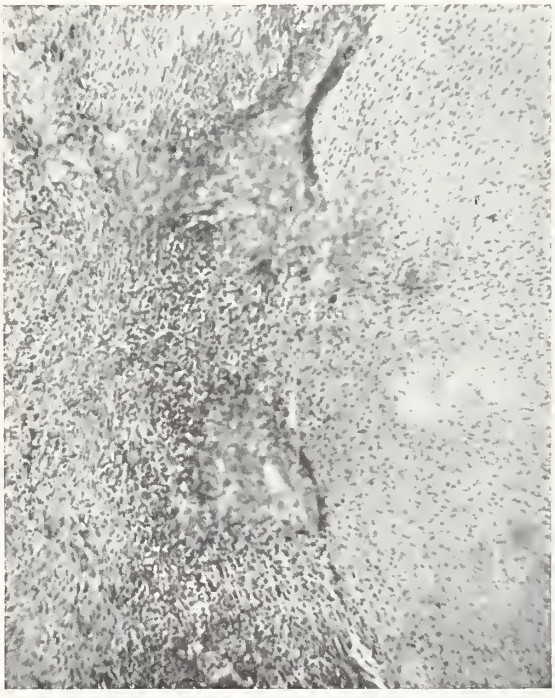
use these terms to denote the amount of pathological involvement. Unless the lobe is removed or the character of the pathology is determined by inspection during open drainage, roentgenological evidence must be used as a criteria for the distinction between simple and complicated. Overholt and Rumel,[3] and Moore,[4] believe that all abscesses should be classified according to the amount of the surrounding pathology. They discount the terms acute and chronic because of the inaccurate time factor, yet Overholt said that most acute simple abscesses are of less than six weeks' duration and the chronic complicated ones are of more than six weeks' duration. The zone of pneumonitis surrounding a simple abscess is less extensive than that in a complicated one. However, it is difficult to determine by x-ray whether a large area of atelectasis and pneumonitis surrounding an abscess will clear up with internal drainage, or whether considerable fibrosis, bronchiectasis, and pneumonitis will require external drainage. Almost all chronic abscesses tend to be complicated because of the long-standing inflammatory process. Therefore, the time factor is intimately related to the pathology. The author believes that in diagnosing an abscess of the lung, terminology noting the time factor and describing the bacterial content and amount of pathological involvement should be used. For example, an abscess should be diagnosed as "acute, putrid, simple abscess," or a "chronic, putrid, complicated abscess." Figure I demonstrates a pathological section of a chronic, putrid, complicated lung abscess. The line of demarcation denotes the edge of the cavity, with the debris to the right and organized tissue to the left. This abscess was complicated due to the fact that the bronchi leading into the abscess cavity were blocked by granulation tissue.

Since most papers on lung abscess stress only a part of the entire diagnosis, results are difficult to evaluate. In order to systematize the usual confusing classifications of various kinds of abscesses, a classification chart with the accompanying clinical complications is presented—Chart I.

[3] Overholt, R. H., and Rumel, W. R.: Factors in the Reduction of Mortality from Pulmonary Abscess, *New England J. Med.*, **224**:441-553, 1941.

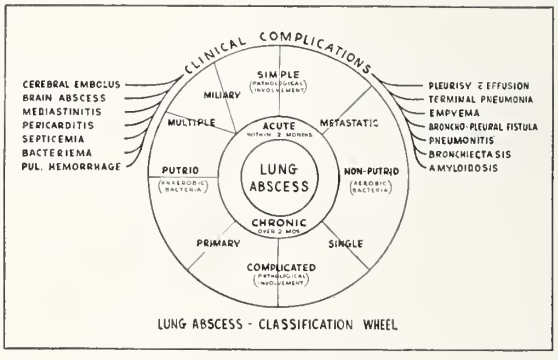
[4] Moore, R. L.: Pulmonary Abscess—Surgical Problem, *Ann. Surg.*, **116**:373-386, 1942.

FIGURE I.



Microphotograph (x 185): Line of demarcation off right center shows wall of abscess cavity. To the right of this is a cross section of the debris in the cavity, and to the left is chronic inflammatory tissue surrounding the cavity.

CHART I



Classification of Lung Abscess.

ETIOLOGY

Two theories are generally advanced as to the etiology of lung abscess, namely, embolic and aspiratory. In addition, lung abscess may be caused by trauma to the chest wall, foreign bodies, stab wounds, or result from an extension of infection elsewhere, particularly from the liver. Embolic abscesses are generally multiple and bilateral, while abscesses due to aspiration are usually single and unilateral. Allen[5] disagrees and thinks aspiratory abscesses are multiple and that embolic ones are single, but Travers[6] states that whether they are single or multiple does not prove their origin. The aspiration of material definitely caused the abscess in twelve cases herein reported—five following tonsillectomy, one following appendectomy, two from pyorrhea, two from teeth extraction, one following childbirth, and one in an insane patient who aspirated food into his lung while being fed with a tube. Nine abscesses followed pneumonia, although in three cases the abscess may have been the initial infection. Formerly pneumonia was considered the primary cause of lung abscess, but now we know that existing pneumonitis is often due to the abscess. Twenty-eight patients gave a history of resulting

[5] Allen, D. S.: Lung Abscess, *Arch. Surg.*, **16**:178, 1928.

[6] Travers, M. P.: Etiology of Lung Abscess, *Medical Record*, **145**:112-114, (Feb. 3) 1937.

abscess following upper respiratory infections. The question arises as to whether the upper respiratory symptoms are caused by the abscess. Rosenblatt[7] thinks that the upper respiratory infection is not a separate entity, followed by lung abscess, but rather an early manifestation of the abscess itself. At any rate a bronchus is blocked, either wholly or partially, by aspirated material or by mucous-like lung secretions which become infected with bacteria. Whether the blockade is embolic or aspiratory, the growth of bacteria is favored by subsequent pulmonary congestion.

The formation of the abscess takes place near a pleural surface, rarely on the diaphragmatic and mediastinal surfaces. They are often interlobar, but most abscesses are adjacent to the ribs' pleural surfaces. Most of the so-called "central abscesses," according to Myers and Blades[8] are merely abscesses located in the apical regions in the lower lobes.

CLINICAL AND LABORATORY FINDINGS

In any patient with suspected lung abscess, tuberculosis must be ruled out by gastric lavage, cultures, or guinea pig inocculation. Abscesses resulting from tumors must be differentiated from primary lung abscess. Suppurative pneumonitis is a separate disease entity, but may be the cause of a lung abscess. Interlobar empyema may be confused with abscess of the lung. The clinical complications which have occured as a result of lung abscess in this and other series of cases are as follows: cerebral embolus, meningitis, brain abscess, mediastinitis, amyloidosis, septicemia, bacteremia, pulmonary hemorrhage, pleurisy with effusion, empyema, terminal pneumonia, bronchopleural fistula, pneumonitis, and bronchiectasis.

All patients in this series had the usual prodromal symptoms of malaise, chills, and fever. These appeared before the onset of fetid breath and expectoration of foul sputum. A great number of patients had chest pain. Hemorrhage was infrequent, although in one case it was the initial symptom. Dyspnea, loss of weight, and secondary anemia are common findings in patients with chronic abscesses. The white blood count varied from ten to twenty thousand, and the sedimentation rate averaged 22 mm. per hour (Cutler Method).

In this series the left lung was involved in twenty-three cases, seven in the upper lobe and sixteen in the lower lobe. The right lung was involved in twenty-seven cases, thirteen in the upper lobe, two in the middle lobe, and twelve in the lower lobe.

All of the abscesses were primary. Ten had multilocular cavitation, as discovered by the method of open drainage. The cases which recovered by means of bronchoscopy, of course, may have had a similar existing condition. Two cases had successive single abscesses in adjacent lobes. Both had an abscess in the lower lobe before the one in the upper lobe appeared.

The age of these patients ranged from fourteen to sixty-four, with a mean age of thirty. As in most other series, the men outnumbered the women by a ratio of two to one. There were thirty-four men and sixteen women. A survey of the literature gives no definite reason for this difference in sex incidence. It may be that lung abscess occurs more frequently in persons who are careless and unclean as regards oral hygiene. This happens more often among men than women. Although lung abscess is no respecter of persons, it is inclined to frequent that class of men known as "bums."

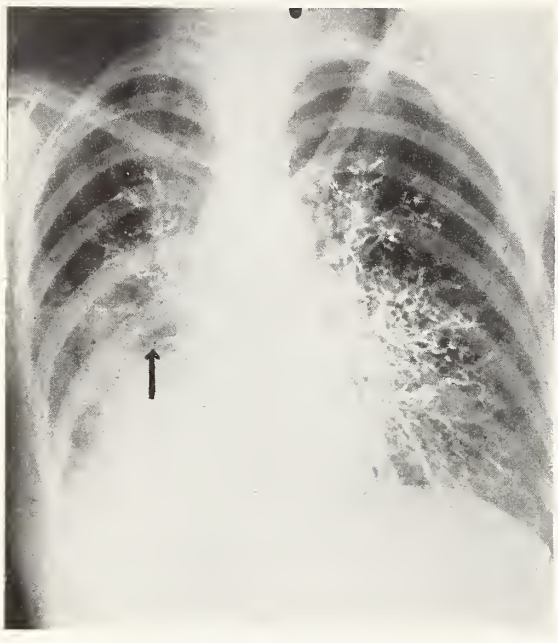
BRONCHOSCOPIC DRAINAGE

All cases in this series were referred to a chest hospital—a few for differential diagnosis, but the majority because conservative measures had failed to heal the abscess. The primary objective in the treatment of lung abscess is adequate drainage, regardless of procedure. Bronchoscopy with lipiodol instillation was employed in all but six cases, in which there was definite evidence that bronchoscopy would be of no avail. Twenty-six cases, ten acute and sixteen chronic, of the fifty were cured by bronchoscopy with lipiodol instillation—Table I. This procedure evidently removed the bronchial obstruction and accompanying atelectasis and allowed the abscess to close spontaneously. Bronchoscopy without the instillation of lipiodol is not as effective as with lipiodol, especially if the abscess is inaccessible to direct suction. After the instillation of lipiodol the patient helps in removing the bronchial blockade by excessive coughing. Often little pus will be obtained during the bronchoscopy, but afterward the patient will evacuate considerable pus during the entire day following the procedure. The degree of pathological involvement can be determined somewhat by the success of the procedure. If this procedure can cause the abscess cavity to collapse, then the pathological involvement around the abscess is not as complicated as the x-ray might indicate. If bronchoscopy does not produce results, complicated pathology is present and open drainage advisable. Figure II-A shows a radiograph of a patient, twenty-four hours postpartum, who had pain in left chest and a productive cough following rib resection for empyema one month prior to this film. Three bronchoscopies furnished adequate drainage for recovery from abscess which is noted in the left lower lobe. Figure II-B shows the same patient four years and ten months following recovery. Fibrosis marks site of the former abscess. Three patients who were bronchoscoped were moribund, and bronchoscopy was used in vain as a possible aid. Penicillin was not available at that time. Since the advent of penicillin two patients were admitted in a moribund condition, and this drug changed the clinical picture so that they be-

[7] Rosenblatt, Milton B.: Putrid Lung Abscess, *J. Thoracic Surg.*, **9**:294, 1940.

[8] Myers, D. W., and Blades, B.: The Clinical and Roentgenologic Features of Pulmonary Abscess Located in the Superior Division of the Lower Lobes, *J. Thoracic Surg.*, **8**:321-328, 1939.

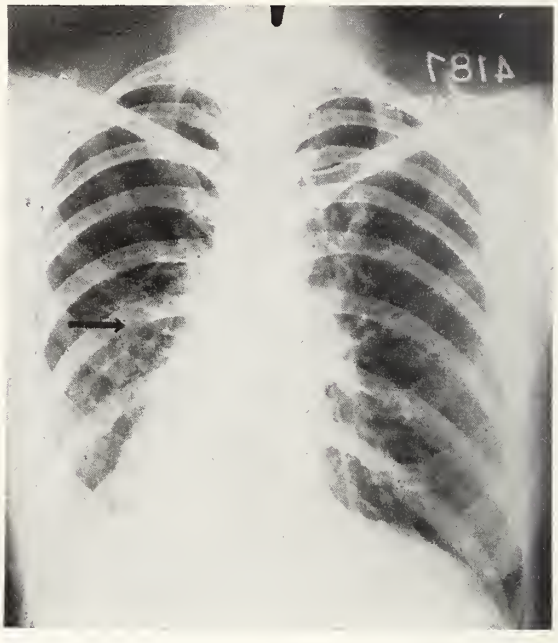
FIGURE II-A.



Lung Abscess Left Lower Lobe.

Case No. 4187—5-29-39: Patient aged thirty-two, twenty-four hours postpartum—pain in left chest, productive cough, rib resection for empyema done 4-20-39, which did not drain. Admitted 5-22-39 with temperature 101, pulse 80, and abscess left lower lobe. Three bronchoscopies furnished adequate drainage for recovery.

FIGURE II-B.



Arrow points to residual fibrosis at the site of former lung abscess.

Case No. 4187—3-14-44: Radiograph taken four years and ten months after recovery. Patient had a bronchitis and desired a check-up. Fibrosis marks site of former lung abscess.

came good operative risks. Penicillin and sulfonamides are valuable aids in the treatment of lung abscess, but to adhere to drug therapy alone is mumpsimus.

The author believes that bronchoscopy should not be classified as a medical procedure like postural drainage. Garvin's postural drainage is more or less a therapeutic failure, because its mortality rate subalternates the cure rate. Heuer[9] says, "postural drainage achieves 25 per cent satisfactory results at a cost of 25 per cent mortality." Postural drainage should be employed between bronchoscopic treatments and should never be substituted for it.

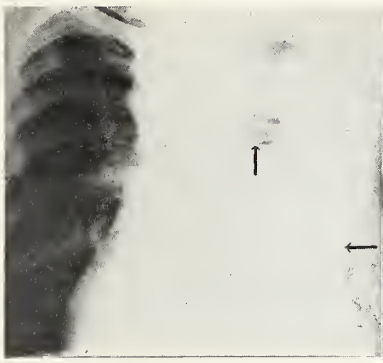
SURGICAL DRAINAGE—HALF DOLLAR TECHNIQUE

None of the abscesses were treated according to the method originated by Neuhof and Touroff,[1] who use the one-stage operation. The standard two-stage operation, whereby a gauze pack is used for pleural symphysis, was modified by the author by use of the half-dollar technique. Two rib sections are generally excised. A half dollar, instead of just gauze packing for pleural symphysis, is placed on the parietal pleura after the removal of rib sections and muscle bundle. Iodoform gauze is packed on and around the half dollar. This insures the adherence of the two pleural surfaces and assists in the localization of the abscess by the use of the half dollar as a marker. A follow-up stereoscopic x-ray can, therefore, show the relation between the abscess and the half dollar. The half dollar, after removal, leaves its contour upon the parietal pleura, and the abscess can be entered with reference to the circumference of the coin. The coin and pack are left in place for seven days, after which the cavity is needled and opened by cautery. After the abscess is opened by cautery the cavity is packed with gauze, a method originated by Conners, according to Case.[10] The wound is left wide open. This is facilitated by a Y-incision. In addition to daily packing, irrigation of 5 per cent sulfathiazole solution, saline, or hydrogen peroxide is used once or twice a day to wash out the cavity. This through-and-through drainage permits the patient to cough up considerable quantities of pus, especially when the inflammatory process extends all the way from the abscess to the hilus of the lung. We have never experienced the drowning of normal lung tissue or the development of another lung abscess by the use of irrigation. Packing and irrigating are continued until the wound is practically closed. Plastic surgery may be necessary to close the wound, and sometimes a muscle block may be needed to fill an open bronchus, if silver nitrate,

[9] Heuer, G. T.: The Treatment of the Acute or Recent Pulmonary Abscess, *Surg. Gynec. and Obst.*, **70**:472-478, 1940.

[10] Case, Thomas C.: Pulmonary Abscess, with Special Reference to Packing Treatment of Connors, *New York State J. Med.*, **35**:981-985, 1935.

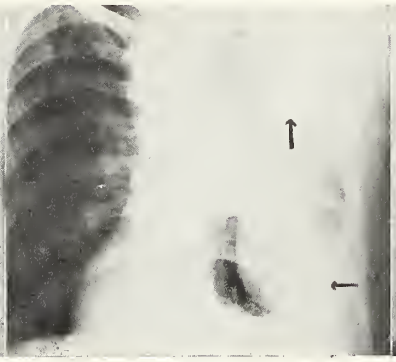
FIGURE III-A.



Lung abseess right upper lobe, complicated with empyema.

Cnse Na. 5898 — 10-19-44: Patient aged forty-ane; ill one year, acutely ill ane manth. Weight loss fifty paunds, with eough, and sputum production of four to six aunees. Vincent's spirachete. Sedimentntion, 3 mm.; white bload eount 37,500; hemaglabin 42 per eent; red blaod count 2,700,000; temperature 102; pulse 120—moribund. Blood transfusians; 700,000 units of penicillin, and open drainage of empyema during first two weeks.

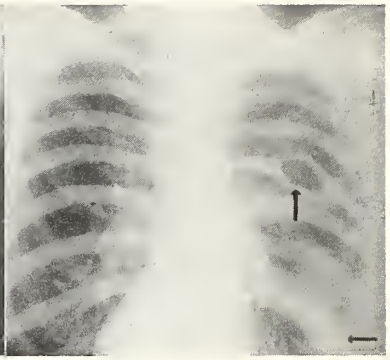
FIGURE III-B.



Empyema adequately drnined. Section of sixth rib removed nnd half dollar placed over site of abseess far purpose of pressure and loealization.

Case Na. 5898—11-24-44: One month after ndmissian. Sectian of sixth pasterior rib removed; packed with gnuze and hnlf dollnr far added pressure on pleura. Film taken day abscess was apened with enutery. Abscess cavity irrigated with sulfa 5 per cent.

FIGURE III-C.



Regenerated rib shows loeatian of former abseess in the upper labe. Residual fibrosis and pleuritis in the lower lobe are result of former empyema.

Case No. 5898—3-3-45: Patient discharged three months after admission. Film taken two months after discharge. Regenerated rib marks site of abscess, thickened pleura site of empyema.

silk sutures, or the like is not effective. Figure III-A shows a radiograph of a male patient, aged forty-one, who had been ill for one year, and acutely ill for one month; patient had cough, sputum production, weight loss of fifty pounds, and was moribund on admission. During the first two weeks of treatment the patient was given 700,000 units of penicillin, blood transfusions, and open drainage of empyema was instituted. Figure III-B shows film taken one month after admission. Section of the sixth rib posteriorly was removed and the half-dollar technique, as described above, applied. The abscess cavity was irrigated with sulfathiazole solution 5 per cent. This film was taken on the day the abscess was opened with cautery. Figure III-C shows a radiograph of this same patient three months after admission and two months after patient was discharged. Arrows point to site of abscess, showing regenerated rib and thickened pleura site of empyema.

ANESTHESIA

Nitrous oxide and oxygen anesthesia was used for the initial stage. The cough reflex is preserved with general anesthesia. Sodium pentothal and evipal were used for the cavernostomy operation, when the cough reflex needs to be suppressed.

COMMENT

Pneumothorax and phrenic nerve operations are contraindicated in all cases of lung abscess. Two patients not included in this series had pneumothorax for lung abscess. Both developed empyema, and one carried a drainage tube for six years until several thoracoplasties approximated the two pleurae. Empyema masked the exact location of the abscess in five lower lobe cases. The empyema cavity was drained, and after approximation of the pleurae the abscess was opened.

Lobectomy or pneumonectomy was not considered advisable in any of the twenty-one chronic cases which had external drainage. They were all complicated abscesses, and most patients were not considered good operative risks for lobectomy. Several patients experienced small pulmonary hemorrhage during convalescence, and a few patients developed some bronchiectasis following the two-stage operation, but none severe enough to warrant lobectomy. In 1944, Brantigan and Looper[11] reported a mortality of 12.5 per cent in eight patients who had lobectomy for lung abscess. They also quoted from the literature a total of thirty-four cases with seven deaths, a mortality of 20.5 per cent. In the series of twenty-one patients operated by the two-stage operation, fourteen, or 66.7 per cent, are well; two, or 9.5 per cent, are improved, while five are dead, a mortality of 23.8 per cent—Table I.

Of the eight patients who died, one developed brain abscess following a lung abscess which was

[11] Brantigan, O. C., and Looper, E. A.: The Etiology and Surgical Treatment of Lung Abscess, *J. Southern Med. Assn.*, **37**, No. 4, 1944.

TABLE I

Results of Bronchoscopic Drainage

Putrid Lung Abscess	Duration	Number of Cases	Well		Improved		Deceased	
			No.	Per Cent	No.	Per Cent	No.	Per Cent
Acute	Under 2 Mos.	10	10	100.0	.....	.....	.....	.....
Chronic	Over 2 Mos.	19	16	84.2	.....	.....	3*	15.8

Results of Surgical Drainage (Two-Stage Operation)

Acute	Under 2 Mos.	.....	.....	.....	.....	.....	.....	.....
Chronic	Over 2 Mos.	21	14	66.7	2	9.5	5	23.8

* Moribund on admission.

caused by an esophageal fistula. One patient with multiple abscesses died of pulmonary hemorrhage, due to sloughing of the eschar. One patient committed suicide by taking morphine, but would have died anyway from septicemia due to Vincent's and fusiform spirilla. Two died from terminal pneumonia and four were moribund upon admission, and one recovered with penicillin and open drainage, but later died of hemorrhage from a duodenal ulcer.

RESULTS OF OTHER SERIES

In 1936, Allen and Blackman[12] quoted a general mortality of 34.3 per cent from a series of 2,115 cases of lung abscess collected in the literature. The same year Freedlander,[13] in a series of 238 cases, reported a mortality of 40.3 per cent, with 33.1 per cent classified as well. In 1940, Geary[14] had a mortality of 24.3 per cent in forty-one cases. Neuhof and Touroff[15] the same year reported a series of eighty-six acute, putrid abscesses, operated on by the one-stage method, with a mortality of 3.6 per cent. They evidently had the advantage of seeing early referred cases. In 1941, Overholt and Rumel,[3] using Neuhof and Touroff's method, reported that thirty-five single lung abscesses had an operative mortality of 6 per cent, with a cure rate of 94 per cent, and twenty-eight complicated lung abscesses had an operative mortality of 32 per cent and a cure rate of 26 per cent by external drainage. Ten acute cases in this series had a 100 per cent cure rate by bronchoscopic drainage. In 1942, Shaw,[16] using Neuhof's method, reported on forty-nine cases of lung abscess, of whom thirty, or 61.2 per cent, were well (eleven by non-surgical measures); twelve, or 24.5 per cent, improved; and seven, or 14.3 per cent, died. Jackson and Judd[2] treated one hundred fifteen cases by bronchoscopy, with 36 per cent mortality. In this series where bronchoscopic and surgical drainage were combined the mortality rate was 16 per cent — Table II.

[12] Allen, C. I., and Blackman, J. F.: Treatment of Lung Abscess, *J. Thoracic Surg.*, **6**:156, 1936.

[13] Freedlander, S. O.: Total Pneumonectomy for Pulmonary Suppuration, *Ohio State Med. J.*, **33**:769-776, 1937.

[14] Geary, P.: Pulmonary Abscess, Analysis of Forty-one Cases, *J. Med. Soc. New Jersey*, **37**:297, 1940.

[15] Neuhof, H., and Touroff, A. S. W.: Acute Putrid Abscess of the Lung, *J. Thoracic Surg.*, **9**:439, 1940.

[16] Shaw, Robert R.: Pulmonary Abscess, *J. Thoracic Surg.*, **11**:453, 1942.

TABLE II

Summary of
Results in Fifty Unselected Cases of Putrid Lung Abscess

Kind of Drainage	Number of Cases	Well		Improved		Deceased	
		No.	Per Cent	No.	Per Cent	No.	Per Cent
Bronchoscopic	29	26	89.7	.....	.....	3	10.3
Surgical (Two-stage Operation)	21	14	66.7	2	9.5	5	23.8
Total	50	40	80.0	2	4.0	8	16.0

This could have been greatly reduced had all the patients been treated by more radical procedures during the acute stage of the lung abscess.

SUMMARY

1. Early bronchoscopic drainage with lipiodol instillation of lung abscess often opens blockaded bronchi, drains the cavity, and permits its wall to collapse. If this does not occur and the clinical course of the patient becomes retrogressive, open surgical drainage is demanded.

2. The standard two-stage operation was used, with the exception that a half dollar was placed on the parietal pleura to produce pleural symphysis. The coin aided in the localization of the abscess for needling prior to cavernostomy.

3. Of the fifty cases of putrid lung abscess treated by bronchoscopy and open drainage, forty, or 80 per cent, are well; two, or 4 per cent, are improved; while eight, or 16 per cent, are dead. Of the fifty, ten acute abscesses treated by bronchoscopy had a 100 per cent cure rate.

4. The etiological, clinical, bacteriological, and pathological findings in lung abscess and certain operative procedures are briefly discussed. A classification wheel of lung abscess, for the purpose of systematizing various diagnoses, is presented.

MÉNIÉRE'S SYNDROME*

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CHICAGO, ILLINOIS

The first requirement in any discussion of Ménière's syndrome is to establish a clear understanding of what is meant by the terms Ménière's disease, Ménière's syndrome, or symptom complex and pseudo-Ménière's syndrome.

The origin of the term Ménière's disease dates back to the case described by Ménière in 1848, and again in 1861. This description, as translated[1] from the *Gazette Medicale de Paris* for September 21, 1861, contained the following: "I have spoken elsewhere a long time ago of a girl who having journeyed by night in winter on the box seat of a stage coach during her catamenia became as a result of the severe cold completely and suddenly deaf. Admitted to the service of M. Chomel, she presented as the principal symptom continuous vertigo—the least effort at movement caused vomiting, and death took place on the fifth day.

"The autopsy showed that the brain, the cerebellum, and the spinal cord were absolutely free from any change, but, as the patient had become completely deaf after having always heard perfectly, I removed the temporal bones in order to investigate thoroughly what could be the cause of this complete deafness. The semicircular canals were filled with a red plastic material, a sort of bloody exudate, a few traces of which were discovered with difficulty in the vestibule, and which did not exist at all in the cochlea."

The "elsewhere" mentioned in Ménière's first paragraph referred to a brief description of the same case by Ménière in 1848 as a translator's note in a book by Kramer, translated by Ménière. This note failed to mention the existence of vertigo, but referred only to the sudden complete deafness and the finding of a plastic reddish lymph throughout the labyrinth.

According to these dscriptions the nature of the fluid in the labyrinth was not definitely determined, but could have been either an inflammatory exudate or hemorrhage. Since neither of these conditions constitutes a cause of death, and intracranial disease was stated to be absent, the diagnosis remained in doubt. A hemorrhage into the inner ear in the late stage of leukemia would seem to be the most probable explanation.

Following these reports the term "Ménière's disease" was applied to the syndrome of sudden vertigo, associated with deafness and tinnitus. In later years the realization that these symptoms might result from more than one type of disturbance of the inner ear led to the preference of the term "Ménière's syndrome." This term has been customarily used in a broad sense to include practically all disturbances of the inner ear or eighth nerve, which could not be explained on the basis of suppurative labyrinthitis, tumor, or trauma. Clinical observation along with gradually-increasing pathologic information has made it possible to distinguish several disease entities affecting the inner ear, all of which have been loosely classed under the symptomatic diagnosis of Ménière's syndrome.

In recent years the term "Ménière's disease" has again come into popular use in reference to one definite clinical group characterized by recurring attacks of vertigo, along with fluctuating tinnitus and deafness. The attacks of vertigo are irregular and sporadic, but the deafness, although fluctuating, pursues a progressive course. The underlying pathology in this group has been shown in recent years to be a labyrinthine dropsy, or dilatation of the endolymphatic spaces in the labyrinth.

* Presented before the General Meeting of the Indiana State Medical Association, at French Lick, November 8, 1945.

† From the Division of Otolaryngology, University of Chicago, Chicago, Illinois.

[1] Atkinson, Miles: Ménière's Famous Autopsy and Its Interpretation, *Arch. Otolaryng.* **42**: 186-187 (Sept.) 1945.

The term "Ménière's disease," as now understood, refers therefore to only one type of inner ear disturbance among several which are sometimes included under "Ménière's syndrome."

The symptom of vertigo both in the form of attacks and as a result of assuming certain postures is also common to a number of diseases of the central nervous system, especially those involving the posterior cranial fossa. The diagnosis in such cases is usually determined upon the basis of the associated neurological symptoms and signs.

In clinical practice, however, vertigo often occurs without either associated neurological signs or auditory disturbances. In such cases the disturbance could not be attributed definitely to the peripheral ear, and the diagnosis has often remained uncertain. Attacks of vertigo of this type have commonly been classed as "pseudo-Ménière's syndrome."

It now seems definite that the great majority of the pseudo-Ménière's group of vertigoes are due to a disturbance in the central vestibular pathways. The vertigo tends to have a postural character and may be produced by several causes among which are toxic factors, either infection or drugs, and circulatory disturbances, both of the hypertensive and hypotensive types, and may consist of only one attack or may be recurrent.

In a relatively few cases a true Ménière's disease may begin with the symptom of vertigo, but the diagnosis cannot be made until the characteristic auditory changes have made their appearance.

While the so-called "pseudo-Ménière's syndrome" can therefore usually be attributed to a disturbance of the central nervous system, the true "Ménière's syndrome," or "symptom complex," arises always from the peripheral labyrinth or eighth nerve.

The treatment of pseudo-Ménière's syndrome depends upon the etiologic diagnosis. About half of these cases are due to toxic factors, hypertension, and some of unknown etiology.

About one-half fall into the group with abnormally low blood pressure, frequently with headaches, gastro-intestinal disturbances, and other signs of vasomotor instability. There may be only one attack, or there may be recurrences.

The treatment is directed toward the underlying hypotension. Neither the salt-free diet nor surgery are indicated for relief of this type of vertigo.

DIFFERENTIAL DIAGNOSIS IN "MÉNIÉRE'S SYNDROME" OR "SYMPTOM COMPLEX"

The symptoms of vertigo, tinnitus, and deafness may be produced by a variety of diseases of the inner ear or eighth nerve.

Purulent Labyrinthitis: Purulent labyrinthitis may be readily excluded as a cause for vertigo by the absence of middle ear suppuration.

Labyrinthine Fistula: The existence of a fistula into the labyrinth, such as may occur in cholesteatoma, granuloma, congenital syphilis, or tumor of the temporal bone may be excluded by the fistula test. This test consists of raising or lowering the pressure in the external auditory canal by means of a rubber bulb or bag fitted into the meatus. The occurrence of vertigo and a nystagmus on alteration of pressure indicates the presence of a labyrinthine fistula. The treatment may be surgical or medical, depending upon the etiology.

Concussion: Concussion of the inner ear occurs as a result of direct trauma to the ear or side of the head, and can be differentiated on the basis of history. The deafness and vertigo in such cases may require several hours to develop, but is usually profound. Recovery requires several weeks, and is usually only partial. The clinical course suggests that hemorrhage in the inner ear may have occurred as a result of the trauma.

Fracture: Fractures through the labyrinth result in profound or total loss of function. They occur in the more severe type of head injuries, and if recovery takes place the labyrinthine disturbance is usually obscured by the cerebral symptoms for several days. The loss of function of the ear, both auditory and vestibular, is permanent, and the fracture line may often be shown on appropriate roentgenograms of the temporal bone.

Tumors: Tumors of the eighth nerve or the cerebellopontine angle may sometimes be confused with Ménière's syndrome in the early stages. Such tumors usually cause tinnitus and nerve deafness, which progresses steadily to complete deafness in from several months to one or two years. Attacks of vertigo may not be prominent, but there is a rapid loss of vestibular function in the affected ear, and the roentgenograms may show dilatation of the internal auditory meatus. As such tumors progress in size, other neurological signs appear, such as loss of the corneal reflex, facial weakness, and headache.

Ménière's Syndrome: In addition to these inner ear diseases in which the etiology and pathology have long been well known there exists the group which, because of lack of knowledge as to the pathologic basis, has been classed as "Ménière's syndrome."

1. Hemorrhage or thrombosis:

The general impression resulting from Ménière's first case report was that a hemorrhage into the labyrinth constituted the pathologic basis of Ménière's disease. While a hemorrhage into the labyrinth constitutes a definite clinical entity, it has no relation to the clinical condition now commonly referred to as Ménière's disease.

A hemorrhage or thrombosis in the labyrinth is a relatively rare occurrence which is diagnosed chiefly on the clinical findings. There is a sudden onset of vertigo, vomiting, tinnitus, and deafness which reaches a maximum within a few minutes or hours. The vertigo subsides gradually over a period of weeks. The loss of auditory function is profound, and recovery does not occur or is only slight. There is no recurrence of the attack. While pathologic information has been rarely obtained in such cases, the course of the disease and its occurrence in middle or past middle life points strongly to a vascular lesion. The treatment is only symptomatic, con-

sisting of absolute rest during the acute stage along with mild sedation.

2. Toxic neuritis:

Toxic neuritis involving the eighth nerve has also been frequently classed under Ménière's syndrome. The eighth nerve may show a sensitivity to certain drugs, for instance tobacco, and vertigo and tinnitus result. Drugs such as quinine, salicylates, and alcohol produce auditory symptoms early, and in heavier dosage may produce vertigo.

Certain infections seem to have an affinity for the eighth nerve. Unilateral deafness is common after an attack of mumps and may be associated with vertigo for a few days at the onset. The deafness is permanent and complete. Unilateral deafness along with vertigo may occur as part of the Ramsey Hunt syndrome, as well as in other infections, sometimes of an obscure nature. The vestibular nerve is less susceptible to toxic effects than the auditory nerve, and usually does not suffer permanent damage.

3. Non-suppurative otitis media:

An acute or subacute catarrhal inflammation of the middle ear may sometimes cause an acute attack of vertigo. It has usually been associated with tubal obstruction and accumulation of fluid in the middle ear. Whether the inner ear involvement is explainable on a toxic basis or a disturbance of pressure relationships is not clear, but relief may usually be obtained by inflation of the middle ear or incision of the ear drum and removal of fluid.

4. Allergic reaction:

An acute attack of vertigo on rare occasions has been observed in association with an acute allergic reaction. The theory has also been advanced that allergy is the etiology of labyrinthine dropsy. Clinical observation indicates, however, that a possible association between a true Ménière's disease and an allergic reaction could only be assumed in rare instances. An attack of vertigo in association with an allergic reaction is not readily explainable, but could occur indirectly as the result of tubal obstruction. Treatment should be directed toward relief of any tubal obstruction by the use of vasoconstrictor drugs, and, if possible, the avoidance of the offending allergen.

5. Labyrinthine dropsy:

Ménière's Disease: As mentioned earlier, the name "Ménière's disease" has in recent years been applied only to the clear-cut clinical syndrome of recurring attacks of vertigo associated with tinnitus and deafness of a fluctuating character. This disease may start in middle life, sometimes as early as the third, but more often in the fifth and sixth decades. Vertigo may be the first symptom, but more often tinnitus, a sense of blockage in the ear, or deafness appear first. The deafness may involve only the lower frequencies in the early stages, but is usually progressive, eventually involving all frequencies for both air and bone-conducted sound. One or both ears may be affected. The disease also frequently makes its appearance in cases of bilateral high tone deafness, and in these it often develops in only one ear. The vertigo is the chief concern of the patient, since the attacks are incapacitating, but the frequency and duration of attacks is extremely variable. In many instances the attacks become less frequent and less severe after the first few years. In some the vertigo may only have occurred at the onset, and is later forgotten or has never been attributed to the ear. It appears also that in some cases of labyrinthine, dropsy vertigo may never occur, although the tinnitus and deafness progress in a typical manner.

The loss of hearing is a constant symptom, usually progressive, eventually becoming profound, and in bilateral cases causes a serious handicap.

Pathology: The endolymphatic system of the labyrinth becomes dilated at the expense of the perilymphatic space in which it is suspended. The special sensory structures are situated within the endolymphatic spaces. The disturbances of function appear explained in part on the basis of distortion of membranous structures, possibly also by disturbances of pressure relationship, and in some by eventual degeneration of neural elements.

Etiology: The etiology is indefinite. "Hydrops labyrinthi," which occurs in connection with some other ear diseases, is associated with an extensive inflammatory reaction. In this type there is no histological evidence of eosinophilic or other cellular infiltration in the early stages.

It is not clear whether the increase in endolymph represents an increase in secretion, a failure in excretion, or an alteration in chemical constitution. Physical allergy has been proposed by Williams, of the Mayo Clinic, as the etiological factor. Clinical observations do not suggest any relationship to extrinsic allergy.

Functional Tests: Two types of auditory threshhold curves are seen in the early stages of the disease. One type shows a low tone loss of air and bone conducted sound with preservation of high tones. The other type occurs in cases with an already-existing bilateral high tone deafness, and appears as a superimposed low tone deafness and sensation of blockage limited usually to one ear.

The low tone deafness is widely fluctuating in the earlier stages. The vertigo is most likely to occur at the time when the deafness and noises are approaching a peak. Following an attack of vertigo, accompanied usually by vomiting and sometimes diarrhea, the subjective auditory symptoms are relieved. The deafness becomes progressively worse despite fluctuations and eventually all tones are affected to a similar extent. One or both ears may be affected, unilateral involvement being in the majority.

Vestibular function as indicated by the cold caloric test is usually normal in early cases, but may show fluctuation in the responses. In advanced cases a mild degree of impairment is present.

TREATMENT

Medical Treatment: The treatment is usually directed toward relief and prevention of vertigo because of its distressing character. In former years

the vertigo was often attributed to gall bladder disease and treated by mild laxatives, and sometimes by gall bladder surgery. Treatments which have been most popular in recent years have consisted basically in control of fluid balance.

Mygind and Dederding, of Copenhagen, who made an exhaustive study of the disease, recommended restriction of salt. They showed that rapid intake of a large amount of fluid by such a patient often produced within a few hours an increase in deafness and sometimes an attack of vertigo.

Furstenberg, Lashmet and Lathrop, of Ann Arbor, recommended strict elimination of sodium from the diet, and the use of ammonium chloride, gm. 6.0 to 9.0 daily, for alternate periods of three days each.

A more practical and equally successful method of treatment in our hands has been careful restriction of sodium chloride in the diet, an even distribution of intake of fluids and food throughout the waking hours, and potassium chloride, 25 per cent solution, two teaspoonfuls twice daily in a small amount of tomato juice at the beginning of the meal.

The object of the treatment is to promote removal of body fluids. A mildly laxative effect may sometimes be produced by the potassium chloride.

Other treatments which have been popular are the use of histamine, as recommended by Horton, of the Mayo Clinic, for the alleviation of acute vertigo, and the use of both histamine (Horton) and nicotinic acid (Atkinson) for prevention of attacks of vertigo. In our experience these treatments have not proved successful in preventing the attacks.

Atropine has met with favor for alleviation of acute symptoms. Pilocarpine and epinephrine have also been recommended for this purpose. Inflation of eustachian tubes has been completely ineffective in the treatment of Méniére's disease in our hands, but has been of value in the treatment of vertigo associated with tubal obstruction and catarrhal otitis media.

It must be emphasized that the attacks of vertigo show great variability in frequency and severity independently of treatment; also that the auditory threshold varies widely from day to day in the normal course of the disease. Therefore, an attempt at evaluation of a method of treatment on the basis of symptoms must take these normal fluctuations of the disease into account.

Surgical Treatment: The distressing character of the vertigo and the dangers incident to an unexpected attack warrant the consideration of surgery whenever medical treatment fails to give relief. Several methods of surgical treatment have been developed and are in use.

Intracranial section of the vestibular portion of the eighth nerve has been practiced with success by Dandy and certain other operators. The treatment is theoretically an ideal one for relief of vertigo and preservation of hearing. The procedure appears not to have met with the same unanimous success in the hands of all neurosurgeons.

Destruction of the labyrinth by means of alcohol injection or intralabyrinthine surgery has been practiced chiefly in England, but has the disadvantage of destroying hearing as well.

The operation of Portmann, of Bordeaux, which consists of opening the saccus endolymphaticus, preserves the hearing but has not become widely popular because of recurrence of vertigo in a moderate percentage of cases.

More recently Kenneth Day, of Pittsburgh, has demonstrated the possibility of relieving the vertigo while preserving the hearing by insertion of a coagulating point through the ampulla of the horizontal canal and applying a mild coagulating current.

The results that have accumulated up to the present by surgical intervention seem to warrant surgery only in selected cases which have failed to respond to medical treatment. The comparative absence of risk connected with labyrinthine surgery may be expected to recommend this type of treatment if and when preservation of the hearing can at the same time be safeguarded with reasonable certainty.

SUMMARY

The term "Méniére's syndrome," as now generally interpreted, includes several inner ear diseases which may be distinguished clinically. The term "Meniere's disease," originally associated with hemorrhage into the labyrinth, has in recent years been applied only to the syndrome of recurring vertigo and fluctuating auditory disturbances. This disease is progressive, leading usually to severe deafness. The pathologic lesion consists of labyrinthine dropsy, of indefinite etiology.

Other causes for Méniére's syndrome which may be differentiated are intralabyrinthine hemorrhage or thrombosis, toxic neuritis of the eighth nerve, vertigo associated with tubal obstruction, catarrhal otitis media, and possibly allergy.

The term "pseudo-Méniére's disease" has been used to refer to attacks of vertigo which are not associated with auditory disturbances or other neurologic manifestations. Such attacks are in the majority due to a disturbance of the central vestibular pathways. Disturbances of circulation incident to hypertension and hypotension, as well as toxic factors, may constitute the etiology.

The medical and surgical treatments of Méniére's disease or labyrinthine dropsy are reviewed.

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JANUARY, 1946

Editorials

THE DAWN OF NINETEEN HUNDRED FORTY-SIX

For several years past we have aproached the annual duty of writing an editorial on the New Year with much misgiving; there was so little one could say about the proverbial "Happy New Year" when the entire world was at war; when grief, distress, want, and starvation was paramount in so many lands; when men were fighting one another in almost every square mile of the globe. The word "Happy" was out, so far as most of us were concerned; we had other things to occupy our mind and attention.

But 1946 dawns with a new meaning—a new world, one might say. The war has ended, and while we now are concerned with postwar problems, some of which will not be properly solved for a long time to come, there is now a happier future before us, and we again find ourselves without the restrictions that bound us down during the time of war. We have more food and more of the various necessities of life—not all that everyone would wish, but enough to meet our present needs.

The medical profession has reason to be happier in this year of 1946 than for some time past, chiefly because thousands of our members are now returning from service, ready again to take their places in the medical world. It is good to have them back with us after so long an absence, and to know that soon they will take over many of the duties that have been ours during these long years. It means a little more rest and recreation for those of us who remained at home; and it means a surcease from the rigid rules of Army routine for those who have returned to their homes and their practices.

We look to 1946 with much hope, with the belief that in a short time our old routine will again be established, when we again can lead normal lives.

THE JOURNAL wishes everyone a HAPPY NEW YEAR—a year that will open for you a pathway to your most cherished desires.

THE SECTION ON GENERAL PRACTICE

One of the most forward steps taken by the House of Delegates of the Indiana State Medical Association in recent years was the establishing of a new section, that of the Section on General Practice. We recall the early days when there were no sections; at our annual conventions there was only a "general" meeting, at which time all members in attendance sat in one group, there to hear various phases of medicine discussed.

Later came the Section on Medicine and the Section on Surgery. After several years, led by George F. Keiper, of Lafayette, a Section on Ophthalmology was established, and still later, after much groundwork and footwork, Floyd T. Romberger succeeded in bringing about the Section on Anesthesia. And now we are more than pleased to announce the Section on General Practice.

Just why this group, at once the most important group in the profession, has so long been neglected is beyond our explanation, but probably because some "Modern Moses" had not risen to lead the way. However, we now have such a section, and from the plans now being pushed we predict that this will be the section of greatest interest in the years to come.

Just who is the "general practitioner?" Our answer to that query is that he is the back-bone of the medical profession, one of the "grass roots," if you please; without him there could be no advancement in medicine, and without him there would be no specialists in our profession, for it is the family doctor who lays the foundation for the success of our specialists. He is the one who first sees the case and makes the initial study of what is going on in the body of the patient; he "works up the case," thus enabling the specialist to carry on from that point with greater accuracy in arriving at the proper conclusion as to what should be done for the patient.

We like to call the general practitioner the "family doctor," for that is just what he is; he

is the man who has been called through many years to see various members of the family when they were ailing; he is the man who knows, probably before he examines the patient, just what to look for, *and what to do for it.* He knows his families, just as the postman, for example, knows his mail delivery route. He has been with that family through all their illnesses, and on many occasions he has served them as counselor in matters not pertaining to bodily ills. We have known family doctors who on occasion have performed the rites of the Church when there was no one else present to perform that duty. In short, the family doctor is the most important member of his profession, as well as the most important man in his local community.

President Ferrell is to appoint a committee of fifteen to make the plans for this new move, and this committee will be headed by Dr. Jacob T. Oliphant, of Farmersburg, recently retired as president of the Indiana State Medical Association. Doctor Oliphant, or "Jake" as he is more intimately known to all the members of the Indiana profession, is the logical head for this group; he has been a family doctor, down in Sullivan County, since his graduation back in 1905.

It is the hope of this committee that the groundwork may soon be laid, looking toward the establishment of a Board on General Practice, this board to issue certificates to worthy members of that branch of the profession, similar to the certificates issued by boards in other branches of medicine.

As one member of this committee has written, "We are trying to launch a campaign to increase the number and to improve the breed of the common variety of family doctors. We believe that this branch of the profession has been a great factor in holding off socialized medicine, and we view with alarm the rapid depletion of ranks of general practitioners. Our hope is to improve the standards of education, to establish a National Board of Certification, and to obtain for the general practitioner the same measure of mutual respect that is shown between specialists."

It is rather a coincidence that only the other day we were looking over the November, 1920, volume of THE JOURNAL. The late Dr. Frank B. Wynn, one of the finest teachers of medicine we ever have known, was at that time writing a series of several articles on Hoosier Medicine, and this particular article was on "the general practitioner." It seems rather odd that Doctor Wynn, twenty-five years ago, was preaching the same doctrine as is now being formulated by this Committee of Fifteen.

THE JOURNAL will go all out in the furtherance of this movement; its columns will be open to comment from members of the committee and from others who may have something to offer in the discussion of the program. As we have said, we believe that this is one of the most forward movements in our history; one that, when the final plans have been adopted and put into execution, will redound to the glories of our great professional body.

THE JOB AHEAD

As Creighton Barker, Secretary of the Connecticut State Medical Society, so well expressed it in an address at our recent French Lick convention, "The war is not over for sick and wounded soldiers, and medicine's responsibility for them has not ended. The glamour may have gone, and the bands stopped playing, but many thousands of American boys will need medical care for years."

Too many folk—and this will include some physicians—once the fighting had ceased, drew a sigh of relief and confidently expected the world to assume a pre-war status. This is reflected in many phases of our national economy. One need but make a casual study of the final War Loan to determine this fact. Other loans made while we were at war were greatly oversubscribed, while this final loan is meeting great difficulties, too many of our people having "let down" after V-J Day.

Our post-war medical problem is a huge one, and we are not yet prepared to cope with it in the most efficient manner, referring, of course, to the need of medical care for those wounded in service. We long have known that this problem was looming directly ahead of us, and tentative plans for meeting it have tentatively been laid, some of these now in actual operation. Changes have been made in the organization of the Veterans Bureau, and a complete reorganization of that facility seems imminent. Yet the big problem of the proper manning of these hospitals, with more to be built and occupied, remains unsolved. The stark, cold fact faces us, that men now in the Medical Corps are not particularly interested in taking staff positions in these hospitals; in fact, the great majority of them have expressed themselves as opposed to such positions; they want to return to civilian life, and at once.

This hospitalization load is heavy right now, and it will increase in years to come. One official of the Procurement and Assignment Service, a man who has been very active in this work during the past five years, hence in a position to know what he is talking about, declares that not until after 1975 will we have passed the peak in the matter of veteran hospitalization.

He further states that right now we are in practically the same situation as confronted us after the close of World War I, and that we presently are no nearer a proper solution of the problem today than we were at that time. We believe that this man has very accurately outlined the situation as it exists today.

There is no question in the mind of any American as to our duty to these wounded men, but how to take care of them in the most efficient manner remains an unanswered problem. Committees have been named and are being named, all over the country, by national, state, and local medical organizations. Some of these already are functioning, trying to work out some plan; others are just being organized. It is, of course, not a local prob-

lem; it is national in character; it affects every section of the nation.

We have a job cut out for us, and it remains to be seen just how we will attack and solve the problem. It is our opinion that unless we do something about it, and soon, Congress will undertake the solution, which we would not like to see happen.

Along with this problem comes another one, one that more personally and directly affects our profession—What about the ex-service medical men? They are being separated from service in large numbers, returning to their former homes, some with definite plans for the future, some with no plans whatever. Civilian housing is a big problem in Indiana, as well as all over the country, while office space, in many communities, is simply not to be had. These are some of the local problems that must be met locally.

Then there is another problem before us, that of the young medical man who went into service, almost directly from medical school. He had no hospital internship, and had no actual practice before entering the service. As one of them has said, "I went directly from internship into the Army and was there for more than four years. My work was almost altogether the primary dressing of wounds; I had no medical experience. Now that I am out, I know practically nothing concerning the newer drugs—the sulfas, penicillin, streptomycin, et cetera; what I need is a good postgraduate course, but I cannot afford to pay for that just now."

Colonel Charles R. Bird, chief of the Indiana Procurement and Assignment Service, could write an interesting book on his experiences with men returning from service; the problems they present to him are numerous and cover the entire category. He has rendered, and still is rendering, an invaluable service, but no one man can meet all the problems that are presented.

This is a job for the Indiana State Medical Association and its entire membership. Every one of our members will have to pitch in and make order out of chaos, for "chaotic" is the one word describing our present plight.

'WAY BACK WHEN

The *New Harmony Times* recently published some data regarding the rates for the travelers who were guests of the Tavern years ago. This tavern, by the way, has been taken over by the State of Indiana, and plans are in the making for repairs, et cetera, that will restore it to its original design.

The tavern rules, which seem to have been strictly enforced, provided that:

"(I) Travelers and visitors on their arrival are respectfully requested to call at the bar and enter their name, place of residence, and destination in a book kept at the bar for that purpose.

"(II) Persons wishing to board by the day, week, month, or year, or any longer period, shall make that known on their arrival; otherwise they will be charged regular tavern rates until they signify their wish to the contrary.

"(III) Boarders by the week, month, or year must pay weekly, and to spare the painful necessity of dunning it is hoped that boarders will attend to this rule specially.

"(IV) Breakfast will be ready at half-past six o'clock, A.M., dinner at twelve o'clock, and supper at half-past five o'clock, P.M. Visitors and boarders are requested to repair to the house at those hours, but not enter the dining room until the small bell rings.

"(V) As the doors will be closed each night precisely at ten o'clock, visitors and boarders are requested to repair to their respective lodging rooms previous to that hour.

"(VI) As this house is kept for the accommodation of visitors and travelers alone, persons belonging to or employed by either of the societies (probably referring to the Rappites and the Owenites) cannot be boarded or lodged at this house.

"(VII) Playing at cards or other games will be wholly inadmissible at this house.

"(VIII) No person can be admitted to the bar except on special invitation by the landlord or the barkeeper.

RATES OF FARE

Each meal's victuals	$ .25
Lodging, per night	$ .12½
Each horse fed	$ .12½
Each horse per night	$ .37½
For lodging, per night, without other accommodations	$ .25
Each person, boarding and lodging, per day	$ .62½
Each man and horse, boarding per day	$1.00
Each person, boarding and lodging, per week	$3.00
Each person, boarding and lodging, per month	$10.00

From time to time we have noted other details of the early days at the tavern, as printed in the *Times*, recalling some of the menus that were placed before the travelers and boarders. It was not at all uncommon to find on the Bill of Fare, in season, all kinds of game, including the upland game along with the wild turkey. As many as a half dozen meat and fowl dishes would appear on the table at one meal; dinner at noon, of course, being the heavy meal of the day.

As for liquors, chiefly whisky and brandy, these were to be had for a pittance, and it is recorded that most residents of that community each year laid in a generous supply of liquid refreshments at a very small outlay.

On various occasions New Harmony has been visited by writers of more or less note who have sought a story of one sort or another, and most

of the tales do more than scratch the surface. New Harmony is a veritable gold mine of information about the early days in Indiana, and it is unfortunate that many of those who knew this early history have passed on without leaving authentic recording of their knowledge.

The late Clarence P. Wolfe, long-time publisher of the *Times*, for years carried a weekly column filled with material of much import to Indiana historians.

Some months ago Louise M. Husband, for years in charge of the New Harmony Library, passed on, and with her passing was lost a fountain of knowledge of the early books of southern Indiana, along with a personal acquaintance with many of the Hoosier pioneers. Her column, "Things That Interest Me," was widely read and almost always contained at least one worth-while historical note.

C. L. Chaffin, compiler of another weekly column, "Commercial Club Notes," probably the most widely-read column in that section of Indiana, has a vast fund of information as to the early days in New Harmony, some from his own observation and some from chats with the pioneers who have gone before. As we have said, it is to be hoped that this data some day may be properly compiled; it will make a valuable addition to the history of the Hoosier State.

Editorial Notes

Haven Emerson, professor emeritus of Public Health in Columbia University, at the recent Health Officers' Conference at French Lick, astounded Indiana folk with the declaration that Indiana ranks near the bottom in the matter of public health expenditures. We shall have to admit that this has been true for a number of years, but at the same time we take much pleasure in recording the fact that such will not be the case, once the new public health setup gets going, which will be as soon as the 1945 legislative enactments are promulgated. With an entire new setup in state health matters, and with the new school of public health in full action, together with appropriate funds to meet the additional expense, Indiana will be well on the way toward the top. As was recently pointed out, Governor Ralph F. Gates has made it clear that his administration is health-minded, and that he proposes to see that the new program is carried out to the letter. One remaining job is to "sell" the people of our state on this better-health program, make them "health conscious," if you please.

1946 Dues are due !
Hand your check to your
county medical society secretary.

A lot of words might be written regarding the costs of federal legislation, if one but took the time to look over the salary lists. The "Washington Letter," sent out each month by The United Public Health League, a western organization maintaining offices in Washington, gives an interesting story on how Congressional committees secure their employes. It is stated that "various departments of government furnish the personnel and pay the salaries of such committee employes." Then follows a list of such employes of the Pepper Committee on War-Time Health and Education. There are *eighteen* such employes listed, the pay roll of these amounting to the tidy sum of $64,465.00, annually. And remember this is a *single* Congressional committee. Of course, it might be well to remember that this is an *important* committee; there is much work to be done, much propaganda to be sent out, in order that the dear public may be properly educated to the needs as proposed in the Pepper Bill. These salaries, it might be noted in passing, range from $2,000.00 to $7,175.00.

Time magazine for November 26 tells of a "Doctor's Day" held in the village of Prentice, Wisconsin, recently. Prentice, with a 1940 population of 452, is located in Price County, well up toward the northern section of Wisconsin, and for some years it was a logging center, which meant that in those days the Finns were predominant in that industry. Dr. George Elliott MacKinnon was graduated from Queens University, Ontario, in 1914, and a short time later established his practice in the small village, remaining there through the years. His was a busy life, as is evidenced by the fact that in that time he had completely worn out, in addition to numerous horses, his sleigh, his buggy, a snowmobile, a Chevvy, a Star, and fifteen Fords. That was the reason his townsmen, aided by countrymen, planned a "Doctor's Day" for him. His wife had connived in the arrangements, and the good doctor knew nothing about the plan until that morning, when he was met by a committee and advised that that was *his* day. A complete program such as only country folk know how to put on covered the entire day, with luncheon, dinner and all that sort of thing. Oh yes, there was a parade, composed chiefly of 450 "babies" from among the hundreds he had delivered, following which he was presented with a new Ford car. The doctor, more used to attending the sick than speech-making, had little to say outwardly, but it was apparent that deep in his heart he had a most hearty appreciation for the party given him. At the close of the festivities, late that evening, the good doctor was handed a check for $1,300.00, as a *real* token of the esteem in which he is held in that community. It might also be mentioned that the doctor finds time to maintain his membership in the Price County (Wisconsin) Medical Society.

Present-day publicity given to a new form of therapy, while very apropos in most instances, carries with it certain dangers. The American public is a reading public, and when the press announces a new discovery they want their physicians to tell them all about it, and in too many cases they hie themselves to the corner drug store and lay in a supply of the drug.

Hygeia, for December, has an editorial on this subject, from the pen of Morris Fishbein, his present subject being "Self-Treatment of Syphilis with Penicillin," which he terms a very dangerous procedure. The press tells of almost miraculous cures through the use of massive doses of penicillin, and since the drug is now available at most pharmacies, Mr. and Mrs. John Public all too often decide to be their own doctor and treat their own case.

It should be stressed that treatment of syphilis with penicillin is largely a matter of "timing," meaning by that that the drug should be used frequently and the dosage regulated according to the case. Then, too, it should be borne in mind that penicillin via the mouth is not as effective as muscular injections.

For some time the American people have been growing "rat conscious," due to authoritative information as to just how much it costs to maintain the rat population of this country, a figure running into the millions, annually. Then, too, publication of case histories of rat-bite infections have aroused the nation as to this menace. Just recently a campaign was begun against this scourge, and in many cities shop windows carried posters announcing that that institution had joined in a warfare against rats.

For several years past we have had some personal experience with rats in our neighborhood, they having "adopted" us because of several open garbage boxes in adjacent alleys. We did a thorough job of trapping, plus the use of squills and other rodent poisons, and in due time we were rid of the rats. But it seems that no one else in the neighborhood was doing anything about it, and in a short time the rats had again appeared.

So it is with much satisfaction that we note in *The Journal of the American Medical Association*, for December 1, that a new poison, the result of wartime experimentation, has been found, one which sanely used will thoroughly eradicate rats from an entire city. This is known to the trade as ANTU (alpha-naphthylthiourea). The information regarding the use of this new powder comes from the Phipps Psychiatric Clinic, at Johns Hopkins Hospital, Baltimore. This material has been used over a period of more than three years, and the present announcement is the first information given to the public.

Health authorities are advised to immediately look into this and at once interest themselves in a real job of rat extermination.

Down in Washington, Dubois County, a question has been raised—Who is going to pay for an audit of the local county hospital recently made by the Indiana State Board of Accounts? From the story in the *Washington Herald* we gather that this was the first time the hospital accounts had been audited, and that the bill therefor was $805.00. (It seems that bills for such auditing usually go to the county or the city, as the case may be, but that a new 1945 law will make such charges apply direct to the institution audited.) So, as matters now stand, there is some question as to who is to pay for the 1945 audit. County hospitals over the state would do well to investigate this matter and to familiarize themselves with the new law governing such cases.

Quentin Pope, staff writer for the *Chicago Tribune*, which paper is decidedly opposed to any form of socialized medicine, writes from New Zealand under date of November twenty-seventh, commenting on the results of state medicine in that large community. Among other things, he says that the hospitals of New Zealand are filled to more than normal capacity by patients, many of whom show no desire to leave these institutions even though they probably would get along as well in their own homes after the acute stage of their illness is past. They experienced no little difficulty in finding bed space for vitally-ill patients as a result of the overcrowding. In many instances families who tire of caring for semi-invalids see to it that they are taken to the hospital for an indefinite stay.

When this system was first instituted some six years ago, it was estimated that the annual cost would be about five million dollars; it is now found that the cost amounts to more than five times that sum, with the costs increasing daily.

Along with these ills it has been discovered that there is a "medical racket" of no mean proportions, in that certain medical men take full advantage of the system and crowd these patients into the hospitals where the medical man can make dozens of "calls" in a short space of time. It is openly charged that in some instances a physician is enabled to make these calls in one afternoon of each week, billing the government for thousands of dollars yearly. It also has been found that prescriptions signed by the doctor are left with the druggist, and the patient calls for his medicine without having seen the doctor.

There is little or no choice of physician; the patient takes whoever may be assigned to treat him. If it is a surgical case and the patient has no liking for the assigned surgeon he may choose one of his own, but in that case he will have to pay the surgical fee.

The writer concludes, "along with these things has been the promotion of a morbid psychology among people now more conscious of their aches and pains than ever before."

Thus, we have another example of government-controlled medicine—it simply does not work out.

President's Page

New Year's Greetings—and may one and all have a Happy and Prosperous New Year!

This being my maiden article for your scrutiny, I assure you that I feel very small in my attempt to put before you a concrete exhibit of the trend of the medical profession. We are now like an army that has been trapped in certain maneuvers and making a valiant attempt to extricate itself from certain destruction if it remains in situ. We are being sniped at from every angle. To enumerate some—government intervention in the practice of medicine, and a number of lay groups which, I am sorry to say, have high-powered guns in the way of votes.

In our former feeble efforts we failed almost completely, and we could almost see the end of the freedom of patient-doctor relation, and all that it stands for. But by a hurried calling up of reinforcements and putting the heat on where it belongs, we are now able to get some results. And from our battle station it begins to look as if we might save more than we had hoped a few months ago.

And to the men who have fought the real battles in this war just ended—we say, "Welcome home, back into the fold of the state association. We pledge ourselves to assist you in every way possible, for you have given so much toward the winning of the war." Let's help them become reinstated in their various communities, and in instances where necessary let us share our office space or living quarters with them. As we all know, the housing situation is a national calamity.

The over-all picture of reconversion from any angle — economical, industrial, medical, et cetera, looks very gloomy at present. It is going to affect every one of us, but, good or bad, we must have an abiding faith in mankind, that it will all come right in time. No man wishes to do his neighbor harm, but sometimes the leaders of men, for their own aggrandizement, overstep the boundaries that were set almost two thousand years ago, and that was—"Do ye unto others as ye would have them do unto you."

The organization of the Section on General Practice is a step in the right direction. Much good can come from this, and I believe that it will become one of the most important sections, but we must support it to the fullest extent. I believe that one of the first efforts of this section will be a movement toward educating the young doctor in the many advantages of general practice, especially in the smaller cities and towns. If we don't do this, many communities will be without medical care. And right here may hinge the question of whether or not socialized medicine is to flourish. Possibly a revamping will be necessary in connection with our educational system whereby some type of training can be given medical students along the line of "General Practice." Another essential is the establishment of clinics or hospitals in such communities, where our highly-trained young medical men can work in surroundings comparable to those in which they trained, thereby establishing medical care that might well forestall brain-trust ideals.

J. E. Farrell

WHY UNITED STATES DOCTORS OPPOSE REGIMENTATION

In an article dealing with medical care for the American people, Louis H. Bauer, M.D., Hempstead, New York, member of the Board of Trustees of the American Medical Association, wrote in the December 1 issue of *The Journal:*

"We are concerned with a problem on which there are sharp differences of opinion. In fact, were there not these differences of opinion there would be no problem.

"As to the ultimate aim we are all agreed. We believe that no one can quarrel with the platform of the American Medical Association, adopted in June, 1944, which calls for 'availability of medical care of a high quality to every person in the United States.' The differences of opinion arise as to how this aim is to be achieved.

"Another point usually lost sight of is the fact that the mere delivery of a quantity of medical care is not solving the problem. The homeopathic precept that the more a thing is diluted the greater its effectiveness went into the discard long ago. What we want is not just more medical care, but more medical care of a high quality.

"The answer to any complex problem is usually not simple but also complex. So, in our problem of medical care, the answer is not a single one but a multiple one. Yet the Social Security Board and Senators Wagner and Murray and Congressman Dingell refuse to admit that there is any possible answer but the single one of a national compulsory sickness insurance, regardless of the fact that nowhere has it been as satisfactory as our own system of private medical care.

"A careful analysis of the situation would seem to indicate that there are certain elemental factors which are responsible for our problem. These factors are (1) improper distribution of doctors; (2) lack of proper diagnostic facilities in certain areas; (3) the costs of illness, particularly so-called 'catastrophic illness'; and (4) a general economic factor. These factors are closely related and cannot be considered separately. Why are certain areas devoid or short of doctors? There are two reasons. One is that certain areas are so sparsely settled that there is no attraction for a doctor, not only because he will have an insufficient number of patients, but because there are no educational or social facilities in which to bring up his children. The other is really the second factor, namely, the lack of proper diagnostic facilities, so that he cannot practice good medicine. In the latter case he either leaves or else he does what to my mind is worse, he stays and practices poor medicine. With further reference to the lack of diagnostic facilities, this lack is usually due to the fact that the community itself cannot support the necessary facilities.

"The third factor, the costs of illness, again is tied up partially with the second; availability or non-availability of proper diagnostic facilities. The high cost of illness is not in ordinary intercurrent illness, but in the cost of diagnosis in the more complicated illnesses, in hospitalization, and in private nursing care. Also in sparsely settled areas the long distances a doctor may have to go increase the cost of his services. Still another important reason is the cost of care of the chronic invalid.

"The fourth factor, the general economic one, is the matter of housing, clothing, nutrition, and sanitation. This is a social problem of the community and not a medical problem, although neglect thereof results in an increase in the prevalence of disease and the necessity for medical care. The solution, however, is not the pouring in of medical care, but preventing the necessity for it."

Commenting on various phases of the program, Dr. Bauer said:

"Prevention of disease by inoculation and curing disease in its early stages are excellent, but it must be remembered that good living conditions, including good nutrition, housing and sanitation, are equally important.

"The American Medical Association has recommended the use of the voluntary insurance principle in the hospitalization as well as the medical care of the indigent.

"There should be continuous surveys of the manner in which existing provisions meet existing needs in order to permit progress. There should be continuous evaluation of medical services so that they may be kept up to the best that can be provided.

"To attract physicians to rural areas there must be adequate diagnostic facilities, and in some cases subsidies may be necessary.

"We are unalterably opposed to the Wagner-Murray-Dingell Bill for the following reasons: It is un-American; it is inordinately expensive, involving an 8 per cent pay roll tax up to $3,600 of income, and this probably inadequate. In fact, a recent economic survey indicates that with a national income of $120,000,000,000 a 15 to 17 per cent tax will be necessary, and even this, perhaps, is inadequate. It sets up another federal bureaucracy with a lay board—the Social Security Board—at its head, to decide all medical matters, and although the administrative head is the Surgeon General, who incidentally usually is, but need not by law be, a physician, nevertheless he is an appointive, not an elective, official and he is subject to the dictates of this lay board; a third party, namely, the government, is brought between the doctor and the patient, and the doctor is responsible to that third party. A poor type of medical care is encouraged—quantity without regard to quality. Inefficiency, red tape, and political medicine will result. Should the bill be enacted, government control would cover not only doctors but eventually dentists, nurses, technicians, hospitals, medical and hospital supplies, and equipment. Notwithstanding Senator Wagner's claim that this bill is not socialized medicine, it is just that. It is paternalistic and inevitably will lead to national socialism."

AMERICAN MEDICAL ASSOCIATION 1945 SESSION

A. S. GIORDANO, M.D.
SOUTH BEND

The first day of the meeting one was impressed by the fact that every delegate was present, together with many of the past presidents of the American Medical Association, as well as those of various state associations. Many of the secretaries and interested members of state societies were also present. Needless to say, the Indiana delegates were there 100 per cent, as were Dr. Mitchell, Dr. McCaskey, and Dr. Nafe.

The first order of business was the selection of a recipient for the Distinguished Service Award, and this was given to Dr. George R. Minot of Boston. This was followed by reports of officers, and some of the highlights of the retiring president are well worth mentioning, although I assume that all members will read these reports when they are published, which will be soon.

Dr. Kretschmer viewed with alarm the gross indifference of so many of our eminent and successful practitioners who hold responsible teaching as well as other positions, and who do not manifest any interest in the work of the county or state societies. He pointed out that it is high time for them to take an active interest in the affairs of American Medicine, and that they should ask themselves, "What can I do for American Medicine?" instead of "What can American Medicine do for me?" He also emphasized that the time has come for American Medicine to make its position clear to the laymen concerning the significance and the consequence of regimentation of patient and physician in legislation such as proposed by the Wagner-Murray-Dingell Bill. They should recognize that this kind of legislation was the beginning of the downfall of the German people.

Another interesting point brought out by Doctor Kretschmer was the fact that the strong pressure to upset our present-day system of practice comes from the areas where the largest number of doctors, hospitals, and medical schools are located. He suggested that county medical societies change the present method of conducting medical meetings individually and unite with several other counties in order to increase their audiences and develop closer contact with physicians from other sections, thus enabling them to enlarge their program and conduct them more in the nature of a postgraduate medical meeting. He also suggested that a definite time be put aside for county medical societies to discuss economic problems, and that they should take the public into their confidence so that they may be made aware of the problems that concern the public as well. This would constitute not only good public relations but public education in medical affairs.

The incoming president reviewed the work of the American Medical Association and pointed out the tremendous amount of work transacted by the House of Delegates in the brief time afforded at such meetings. He felt that two meetings a year should be held by the House in order to expedite the work. This suggestion was later approved by the Reference Committee. Following the report of officers the House received the reports of the standing committees, which represented a tremendous task and accomplishment by the participants. How little the average physician knows of the extent of effort and energy expended by these delegates in order to keep medicine alive and on a high plane! The reports were followed by a discussion of new business, presented in the form of resolutions. I have never heard of so many "whereases" in my life, and these were added to the volume of reports already presented to the Reference Committee.

As I looked over the program I asked myself, "When can these committees digest this tremendous amount of information that has accumulated over the whole year; and when would the time be available to hold hearings?" I soon learned how late into the night and into the following day these committeemen were glued to their chairs in the various committee rooms.

The highlight of the day, however, was the address by General Hawley, of the Veterans Administration. This gentleman produced a very profound and favorable impression on the entire House by his proclamation. He pointed out that in the first World War the Veterans Administration dealt with four million veterans, and that on full-time basis the medical service proved to be very unsatisfactory. Now we are faced with the task of caring for twenty million veterans. At first the Medical Department was hurriedly organized. This was further complicated by the Civil Service control of personnel. Veterans' hospitals often were built in isolated areas, thus isolating the doctors from professional contacts. The present policy is to utilize all veteran hospital facilities located in or near medical centers. If any new ones are to be built they will be placed in such areas. It is planned to utilize on a part-time basis well-trained young medical men and organize well-trained and recognized medical directors on a full-time basis. He pointed out that at the present time veterans in three states —New Jersey, Michigan, and Kansas—are being cared for by local physicians so they need not be away from their families. This system is working satisfactorily, and it is hoped that many more states will adopt this new policy, with local county medical societies in administrative control. He said that both he and General Bradley are opposed to a bill recently presented in Congress which would recognize osteopathy in the Medical Program, and that both have dedicated themselves to the task of

seeing to it that the veterans will receive the best of medical care and that the medical profession shall not be regimented.

Of interest to Indiana physicians is a report of the Reference Committee recommending that a Section on General Practice be established, and this measure was approved by the House. Many resolutions were introduced to the effect that past errors in utilizing medical officers in the Army be avoided in the future, and that strong measures should be advocated for returning medical officers to civilian practice.

A resolution was approved that Congress be made aware of the present situation with reference to the drafting of premedical students, and that it be recommended that premedical students now in service and whose education was interrupted be returned to school.

An interesting incident occurred on the second day which added much color to the meeting of the House. This was in connection with three resolutions presented by the California delegation; and, by the way, this delegation was composed of three men well informed and well versed in the art of political strategy. The resolutions presented expressed a frank dissatisfaction with the editor as to his activities outside the Association and his public appearances. They pointed out that this has created a very unfavorable impression among the public and legislators, to the detriment of the medical profession. Exhibits were presented to substantiate their claims, and they pleaded with the House for an immediate change. This, of course, brought immediate oratorical demonstrations in defense, but when the smoke was cleared by a House vote it developed that sixty of the one hundred sixty-six votes cast were in favor of a change as compared with only nine votes the year before. In discussing this matter with various delegates it was generally felt that the Board of Trustees should take a firm stand on these matters; however, it was considered wise not to make an immediate revolutionary change, so as to maintain unity.

Another interesting incident was the resignation of the speaker of the House, Dr. H. H. Shoulders. It was clear that this was a move preliminary to the election of officers. Dr. Shoulders was nominated and elected as president-elect, but not without a sharp contest by the vivacious McCormick of Ohio. The California delegation succeeded in seating on the Board of Trustees Dr. Dwight Murray, of Los Angeles, a former Hoosier and battle-scarred Californian, and later were added Dr. James Miller, of Hartford, Connecticut, and Dr. John Fitzgibbon, of Oregon.

For an exact account of the numerous reports by the Reference Committees it is well to read them in detail when published, but on the whole one received the impression that there was insufficient time for careful consideration of the large amount of legislative matters that were presented, particularly those dealing with pre-payment medical service and the principle that these be correlated and placed on a national level.

FEDERAL INCOME TAX AND THE MEDICAL PROFESSION

F. SHIRLEY WILCOX

Collector of Internal Revenue

INDIANAPOLIS

Two major tax bills were enacted during the year 1945. The first, approved July 31, 1945, was The Tax Adjustment Act of 1945. That Act was not intended to affect tax rates, but was a reconversion measure enabling business to build up its cash during the period of change-over from war to peacetime production. Corporations were mostly affected by The Tax Adjustment Act.

The Revenue Act of 1945, the second major tax bill enacted during 1945, is primarily a tax-reduction measure for the year 1946 and later years. For individual taxpayers only one provision will affect directly any 1945 or earlier tax liability. The provision is that additional allowance has been made for non-commissioned officers and enlisted men of the United States armed forces. With this one exception The Revenue Act of 1945 will not affect the individual's tax for taxable years beginning prior to January 1, 1946. For that reason this article will be merely a review of the existing federal income tax regulations.

The rates and exemptions for the taxable year 1945 are the same as for the year 1944. The Individual Income Tax Act of 1944 did simplify some of the requirements, but it did not affect, materially, the problem of determining the net income from the medical profession.

The statutory net profit from the medical profession is determined by completing Schedule C of Form 1040 for the year 1945. A written record of receipts and expenditures is highly important to an individual with income from a profession. It is intended that a taxpayer's regular accounts, files of receipts, and usual records shall be sufficient for filing income tax returns, provided that actual and complete information is available and the tax-

payer is prepared to prove the essential reality of claims or statements made.

Expenses deductible in arriving at the net profit, in Line 22, Schedule C, are the normal costs of producing the income. Such expenses must be distinguished from those incurred for the convenience, comfort, or economy of the individual pursuing the profession, or in the nature of loans, gifts, capital investments, and the like. The distinction lies in the purpose and nature of the payment rather than in any account in which it may be charged. Business expenses may include salaries and wages paid, if not in contravention of the Wage and Stabilization Act, interest on business indebtedness, taxes on business and business property (but not Indiana state gross income tax), depreciation, rents, repairs, and other expenses. Other includable items are commissions, supplies, advertising, and insurance payments for one year.

In the case of a professional man, maintenance and repair expenses of an automobile used for professional purposes (but only that portion of the expenses applicable to the professional use) are allowable as well as membership in professional societies, subscriptions to professional journals, current magazines used in the reception room, and fees paid to other professional men for professional assistance.

If a professional man uses his residence as office and home, he may deduct the expense applicable to that part used for professional purposes.

Expenses not deductible include the cost of books and the cost of instruments and equipment having a useful life longer than one year (these are regarded as capital items on which depreciation may be allowable) and membership dues in a purely social club.

The cost of incidental repairs is deductible, provided the property account is not increased by such expenditures, but repairs in the nature of replacements, betterments, and improvements are regarded as capital expenditures and are not deductible. The Indiana state gross income tax is deductible only if the individual itemizes his deductions on Page 3 of Form 1040 for the year 1945 and computes his tax by the actual computation method.

If a physician has other income, such income should be reported on the applicable schedules found on Page 2 of the return, namely: (A) Income from Annuities or Pensions; (B) Income from Rents and Royalties; (D) Gains and Losses from Sales or Exchanges of Capital Assets, etc.; (E) Income from Partnerships, Estates and Trusts, and other sources.

If a physician has income from a farm, the net farm profit is determined by itemizing the farm income and deductions on Form 1040F in the same manner as in previous years. The net farm profit as determined on Form 1040F may be properly indicated in Schedule E under "Other sources." Form 1040F should be attached to Form 1040 when filing. Total income as listed on Page 2 should be entered in Line 4, Page 1, of the Form 1040.

Physicians receiving compensation for personal services subject to the withholding tax should not include such compensation in his total income in Schedule C, but should indicate the amount of such compensation in Item 2, Page 1, of the return.

Total interest and dividends received is to be shown in Line 3, Page 1.

The adjusted gross income for the year 1945 is the amount shown in Line 5, Page 1. The individuals whose adjusted gross income is less than $5,000 will be able to determine their tax from the optional tax table on Form 1040. The amount of tax on the tax table allows for personal deductions, such as contributions, interest paid on personal indebtedness, and personal taxes of approximately ten per cent of the adjusted gross income.

Taxpayers who are not permitted to use the tax table because their adjusted gross income is $5,000 or more may take a standard deduction of $500 in lieu of listing the actual items of deduction. Any taxpayer who elects to compute his tax may itemize his various non-business deductions and credits much the same as for previous years. This would be advantageous only for those whose deductions are in excess of ten per cent of their adjusted gross income.

If the final Form 1040 for the year 1945 is filed on or before January 15, 1946, and the tax as shown due is paid in full, the taxpayer is relieved of filing an amended declaration of estimated income tax, which might otherwise be required on that date. If there has been no material change in the estimated income tax, and the fourth installment of the estimated tax for the year 1945 is paid by January 15, 1946, the due date for filing the final 1945 federal income tax return is March 15, 1946. The payment accompanying a final return must cover the full amount not previously paid in connection with the declaration of estimated tax or through withholding.

On or before March 15, 1946, an individual deriving his income from the medical profession is required to file a declaration of estimated income tax for the year 1946 and pay at least one-fourth of the estimated tax. The estimated tax for the year 1946 should be determined under the rates and exemptions as provided by The Revenue Act of 1945. In all probability the worksheet accompanying the Form 1040-ES, the form to be used in filing the declaration, will provide the necessary information for determining the estimated tax for the year 1946.

It is recommended that if any specific question arises relative to the determination of the federal income tax you communicate with the Collector's Office in Indianapolis, or contact the nearest zone office in Indiana.

SERVICE TO ALL OF THE PEOPLE IS THE PRICE OF MEDICAL FREEDOM

J. T. OLIPHANT, M.D.

FARMERSBURG

In any survey of the alleged reasons for socialized medicine one thing stands out with startling clarity; it is the fact that there is an alarming shortage of family doctors. Only sixty-five per cent of the men engaged in the practice of medicine are general practitioners. This is not enough to supply our population. Only about fifty per cent of the young men coming out of medical schools are now willing to become general practitioners. This number is far below what is required for replacements.

General practice is the backbone of the whole medical structure. A community could get along fairly well without any specialists, but no community can have adequate medical care unless it has enough general practitioners. Today many of our villages and towns have no doctors, and few of our cities have a sufficient number who will make house calls. At the present rate of decrease in voluntary medical service it can be only a short time until the state must, as a duty to its citizens, take some steps to provide medical care at public expense. Members of the medical profession can have no valid objection to this, since the necessity of the many displaces the legal rights of the few.

Much time and effort have been spent in trying to devise a method by which people may insure themselves against medical costs. This is a good precaution in hard times, but during the last three years almost everyone has had enough cash to meet all of his wants. In spite of these good times, with plenty of money, dissatisfaction with the medical profession is growing. What many thousands of our citizens need and want is a good family doctor, whom they may employ at any time and at their own expense.

People are always frightened by illness. They can not distinguish what is serious from that which is trivial; it is all serious to them. Their need is for a doctor who will come to their home, or who can be consulted conveniently at his office. Their preference is for someone they know, and whom they have learned to trust, but they will accept any service that is available. In places where no medical service is to be had, the patient is taken to the nearest hospital in search of a doctor. This is an expensive and cumbersome way to treat the sick, and it is a burden to the already overcrowded hospitals. Families that have had this unpleasant experience are no longer impressed by the "doctor-patient relationship" argument. They have no doctor, and they have a feeling that someone has let them down. They are ready to accept state medicine, or socialized medicine, or any other kind of medicine that will serve their needs.

The young man who wishes to become a specialist should not be criticized. We must have more and better specialists all the time. But we must have more and better general practitioners also, and the reluctance of our young men to enter general practice may cause us to lose our medical freedom.

The Indiana State Medical Association has created a new section devoted to the interests of the General Practice of Medicine. The first duty of this section is to find out why it is now shunned and held in less respect by all doctors than it ever has been before.

The reasons may not be found readily, but if medicine is to retain its liberty they must be found soon. Present methods of teaching may be at fault. All of our medical teachers are specialists of one kind or another, and they may unconsciously stress the desirability for specialization. It may be that the reason is purely economic, since those in the general field are less well paid, and the cost of medical education is extremely high. Perhaps medicine has come to be more of a business and less of a humanitarian profession. Whatever the reason, the fact remains that if the general practice of medicine can not be restored to respectability, and the people of each community can not be given a doctor upon whom they may depend, the end of free and voluntary practice of medicine is at hand. There is no court of appeal. The case rests squarely in the hands of the doctors themselves.

SPECIAL MEETING OF HOUSE OF DELEGATES

Dr. Jesse E. Ferrell, of Fortville, president of the Indiana State Medical Association, has issued a call for the members of the House of Delegates to meet in special session at one o'clock, Sunday afternoon, January 27, 1946, at the Indiana War Memorial Building, 431 North Meridian Street, Indianapolis.

The purpose of the meeting is to receive the Council's recommendation on the kind of company for establishing prepayment medical care insurance in Indiana.

NURSING SERVICE NEEDS

HELEN TEAL, R.N.

Executive Secretary, Indiana State Nurses' Association

INDIANAPOLIS

Indiana continues to need nurses. The slogan may be threadbare, but the facts remain. In this longed-for final winter of the war, the home-front is more sorely pressed by "shortages" in nursing care than in any previous year.

Physicians interested in the quality as well as the quantity of nursing care can assist administrators of nursing services by supporting the continuation of the self-imposed wartime discipline of "essentiality of service." This plan (set forth by the Procurement and Assignment Service for Nurses) was based upon minimum standards of patient care per day, and on the premise that the needs of the patient rather than his ability to pay should have priority of service.

Statistics can be dull reading, but they do throw light upon controversial issues. To those who have noted the increase of student enrollment, from 2,228 in 1941 to 3,105 in 1945, the need for rationing nursing care probably seems unnecessary at this time, but the patient census in Indiana general hospitals (non-federal) increased 17.6 per cent between 1941 and 1944. Considering the continuing census increase, the exodus of married nurses who have worked during their husband's term of military duty, and the nurses obliged by ill health to leave positions, one has three reasons for continuing to evaluate nursing positions as they relate to patient care.

There are at least three hundred unfilled essential nursing positions in Indiana hospitals as of January 1, 1946, although four hundred thirty-five 1945 graduates have accepted essential positions. The cadet nurses pledged to do essential service will be directed to these positions, but acceptance thereof is voluntary.

The nursing service administrators are grateful to the many physicians who have interpreted and supported the program of essentiality, and cooperated with them in utilizing the limited nursing power to the best advantage. The administrators have looked upon this support as a heartening asset in their strenuous days.

The following resolution serves as a criterion for the nursing service distribution:

RESOLUTION ADOPTED BY THE BOARD OF DIRECTORS OF THE INDIANA STATE NURSES' ASSOCIATION

December 4, 1945.

WHEREAS, there are now serious nurse shortages in many areas of Indiana which we must endeavor to meet; and

WHEREAS, we wish to emphasize and bring about the equitable distribution of nurses in order to maintain the best possible nursing service in this postwar period; and

WHEREAS, we hope that every nurse will wish to serve in the position where her ability may be used to the greatest advantage; Therefore be it

RESOLVED, that the following nursing positions be regarded as essential and used as the criteria to be followed until Congress officially declares the war ended.

In General and Specialized Hospitals

All positions related to the care of patients, to teaching, and to administration.

"(a) Number of staff nurses equals number of $\frac{\text{patients x 2.5 nursing hours x 7 days.}}{48}$

(b) For tuberculosis, one nurse to each eight patients.

(c) For mental, one nurse to each six to eight patients, 25 per cent of the total staff should be graduate nurses.

(d) One graduate head nurse or supervisor to each twelve patients."

In Public Health

All positions related to the care of patients.

All positions related to teaching and to the administration of public health nursing services.

All positions designated as essential in 1944, on the basis of one nurse to each 5,000 unit of population.

"P.H.N.—Generalized Nursing—

(a) One nurse to each 5,000 population.

(b) One head nurse or supervisor to each ten nurses."

In Special Services

All positions in doctors' offices, designated as essential in 1944.

All positions in Nursing Service Bureaus, and all registrants designated as essential in 1944.

In Industry

All positions related to the care of patients on the basis of one nurse to each seven hundred employees.

All positions pertaining/related to administration of industrial nursing services.

In Postgraduate Study

Enrollment which will prepare the student for teaching or for a specialized clinical service or field, essentiality to be determined by the director of the school of nursing and by the university's faculty advisor.

PHYSICIANS RELEASED FROM SERVICE

Army Medical Corps Officers Separated from Active Duty

(This is a continuation of the list published in the October, 1945, issue of THE JOURNAL.)

ADAMS COUNTY

Chavinson, Benjamin—Decatur
Daniels, R. E.—Decatur

ALLEN COUNTY

Clark, William R.—Fort Wayne
Cooney, Charles J.—Fort Wayne
Duemling, Arnold H.—Fort Wayne
Englebert, William F.—Fort Wayne
Firestone, Milton H.—Fort Wayne
Glock, Maurice E.—Fort Wayne
Glock, Wayne R.—Fort Wayne
Hardesty, K. C.—Fort Wayne
Havice, Jay F.—Fort Wayne
Kidder, Orva T.—Fort Wayne
McArdle, Edward G.—Fort Wayne
McKeeman, Donald H.—Fort Wayne
Michaelis, Stephen C.—Fort Wayne
Miller, Carl G.—Fort Wayne
Miller, Orval J.—Fort Wayne
Moravec, Arthur E.—Fort Wayne
Mueller, Lawrence W.—Fort Wayne
Oyer, John H.—Fort Wayne
Perrin, Kermit F.—Fort Wayne
Roser, Arthur—Arcola
Rothberg, Maurice—Fort Wayne
Savage, A. R.—Fort Wayne
Somers, Gerald H.—Fort Wayne
Zweig, Elmer S.—Fort Wayne

BARTHOLOMEW COUNTY

Norton, H. J.—Columbus
Schmitt, Richard—Columbus
Sigmund, William B.—Columbus

BENTON COUNTY

Marsh, George W.—Otterbein
Peyton, Frank W.—Otterbein

BOONE COUNTY

Headley, L. M.—Lebanon
Parke, Delmer D.—Lizton
Wisehart, Robert H.—Lebanon

CARROLL COUNTY

McLaughlin, James R.—Flora

CASS COUNTY

Fitzgerald, Brice E.—Logansport
Holmes, Will W.—Logansport
Lybrook, W. B.—Logansport
Rice, Clayton L.—Logansport
Siewert, Otto L.—Royal Center

CLARK COUNTY

Adair, Samuel L.—Jeffersonville
Regan, George L.—Sellersburg

CLAY COUNTY

Palm, John M.—Brazil
Scherb, Burton E.—Clay City
Weber, J. G. S.—Centerpoint

CLINTON COUNTY

Carrel, Francis E.—Frankfort
Dykhuizen, Theodore A.—Frankfort
Erdel, Milton W.—Frankfort

CRAWFORD COUNTY

Lynch, O. R.—Marengo

DAVIESS-MARTIN COUNTY

Blazey, Arthur G.—Washington
Chattin, Vance J.—Washington
Hill, Kenneth G.—Washington
Ingalls, Clair—Washington
Lett, E. B.—Loogootee
McKittrick, Jack—Washington

DEARBORN-OHIO COUNTY

Bennett, Paul E.—Dillsboro
Fagaly, William J.—Lawrenceburg
Manley, Charles N.—Rising Sun

DEKALB COUNTY

Covell, Harry M.—Auburn
Nason, R. A.—Garrett
Nugen, Harold—Auburn
Walsh, Thomas P.—Garrett

DECATUR COUNTY

Acher, Robert Paul—Greensburg
Dickson, Dale D.—Greensburg

DELAWARE COUNTY

Aucreman, Charles J.—Muncie
Garling, L. C.—Muncie
Hall, Orville A.—Muncie
Hurley, John R.—Daleville
Kirshman, F. E.—Muncie
McMichael, R. M.—Muncie
Moss, M. J.—Yorktown
Picha, V. J.—Muncie
Quick, William J.—Muncie
Schulhof, M. G.—Muncie
Weldy, Bryce P.—Hartford City

ELKHART COUNTY

Bender, Robert L.—Elkhart
Fleetwood, R. A.—Nappanee
Fleming, J. Millard—Elkhart
Kendall, Forrest M.—Nappanee
Kistner, A. W.—Elkhart
Koehler, Elmer G.—Elkhart
Martin, Floyd—Goshen
Miller, Malcolm E.—Elkhart
Mishkin, Irving—Elkhart
Pfaff, William A.—Elkhart
Pickard, H. M.—Elkhart
Stout, Richard Brooks—Elkhart
Stubbins, William M.—Elkhart
Vetter, Karl W.—Elkhart

FAYETTE-FRANKLIN COUNTY

Gregg, Albert F.—Connersville
Love, George N.—Connersville

FLOYD COUNTY

Davis, Parvin M.—New Albany

FOUNTAIN-WARREN COUNTY

Fisher, John E.—Attica
Owen, Abraham M.—Attica

FULTON COUNTY

Herendeen, E. V.—Rochester
Richardson, Charles L.—Rochester

GIBSON COUNTY

Hitch, Oliver M.—Princeton
McElroy, Robert S.—Princeton
Wood, Russell W.—Oakland City

GRANT COUNTY

Bloom, A. Ward—Marion
Brown, Robert M.—Marion
King, Peter Campbell—Swayzee
Price, Sidney—Marion
Stewart, J. Hunter—Marion

GREENE COUNTY

Bailey, Edwin B.—Linton
Jones, Paul A.—Linton
Patton, Rudolph F.—Linton
Raney, Ben—Linton
Rotman, Harry G.—Jasonville
Woner, John W.—Linton

HAMILTON COUNTY

Brown, Harry M.—Cicero

HANCOCK COUNTY

Ramage, Walter F.—Fortville
Romack, Howard H.—Greenfield

HARRISON COUNTY

Applegate, F. M.—Corydon

HENRY COUNTY

Dragoo, Farrol A.—Middletown
Harrison, Benjamin L.—New Castle
Harvey, Bennett B.—Knightstown
Marsh, John P.—Blountsville
Spindler, Robert D.—New Castle
Stamper, Joseph H.—Middletown
Thorne, Charles E.—New Castle

HENDRICKS COUNTY

Kilgore, Byron—Danville

HOWARD COUNTY

Boughman, Joseph—Kokomo
Bowers, Copeland—Kokomo
Bowers, John A.—Kokomo
Bruegge, T. J.—Kokomo
Good, R. P.—Kokomo
Paris, Durwood—Kokomo
Wilson, Fred M.—Kokomo

JASPER-NEWTON COUNTY

Dick, Jack—Rensselaer
Openshaw, J. F.—Goodland
Sink, Frank G.—Remington
Washburn, Richard N.—Rensselaer
Yegerlehner, R. S.—Kentland

JAY COUNTY

Hall, E. H.—Dunkirk
Keeling, F. E.—Portland
Lansford, John—Redkey
Oswalt, James T.—Dunkirk

JEFFERSON COUNTY

Denny, Charles W.—Madison

JENNINGS COUNTY

Johnson, Robert B.—Butlerville

JOHNSON COUNTY

Janjigian, Edward—Edinburg
Province, William D.—Franklin
Sheek, Kenneth Ivinson—Greenwood
Sutton, William—Edinburg

KNOX COUNTY

Fox, Francis H.—Bicknell
Meade, Walter W.—Bicknell

KOSCIUSKO COUNTY

Clark, Fred O.—Syracuse
Hillery, J. L.—Silver Lake

LAKE COUNTY

Anderson, Charles P.—Gary
Birdzell, John P.—Crown Point
Carbone, Joseph A.—Gary
Cogswell, Harold D.—Whiting
Comstock, Glenn E.—Gary
Dierolf, Edward J.—Gary
Elliott, Ralph—Gary
Grosso, William G.—East Chicago
Jackman, Abraham I.—Hammond
Kahan, Harry L.—Gary
Kendrick, Frank J.—Gary
Keseric, N. E.—Gary
Kobrin, Meyer W.—Gary
Lorenty, Thaddeus B.—Gary
Modjeski, Raymond J.—Hammond
Remich, A. C.—Hammond
Rubin, Milton—Gary
Shanklin, James G.—Hammond
Siekierski, Joseph—Gary
Smith, Louis D.—East Chicago
Stanley, John S.—East Chicago
Teplinsky, Louis L.—East Chicago

LAPORTE COUNTY

Kemp, John T.—LaPorte
Muhleman, Charles E.—LaPorte
Oak, David Dwight—Hanna

LAWRENCE COUNTY

Dusard, Joseph C.—Bedford
Episcopo, A. R.—Mitchell
Smallwood, R. B.—Bedford

MADISON COUNTY

Armington, Robert—Anderson
Austin, Eugene W.—Anderson
Kelly, Wendell—Anderson
Kendall, Forest M.—Alexandria
Lamey, James L.—Anderson
Lamey, Paul T.—Anderson
Litzenberger, Sam W.—Anderson
Nelson, Paul Leon—Anderson
Nesbit, L. L.—Anderson
Rosenbaum, Lloyd E.—Anderson
Russell, O. Raymond—Frankton
Williams, Robert H.—Anderson

MARSHALL COUNTY

Reed, Donald—Culver

MARION COUNTY

Adkins, Harold C.—Indianapolis
Albertson, Frank P.—Indianapolis
Anderson, Harry B.—Indianapolis
Anderson, James W.—Indianapolis
Appel, Richard H.—Indianapolis
Balch, James F.—Indianapolis
Ball, Joseph E.—Indianapolis
Beams, Ralph H.—Indianapolis
Beard, Paul H.—Indianapolis
Beaver, Howard W.—Indianapolis
Boling, Roderick—Indianapolis
Booher, Norman R.—Indianapolis
Brodie, Donald Wallace—Indianapolis
Brown, Archie E.—Indianapolis
Caplin, Irvin—Indianapolis
Calvy, William James—Indianapolis
Clark, Cyrus J.—Indianapolis
Close, Walter D.—Indianapolis
Colglazier, Donald—Indianapolis
Connoy, Leo Francis—Indianapolis
Cortese, Thomas A.—Indianapolis
Cullen, Paul K.—Indianapolis
Dearmin, Robert M.—Indianapolis
DeArmond, Albert M.—Indianapolis
DeWees, Dwight L.—Indianapolis
Cheney, Fred D.—Indianapolis
Eikenberry, H. W.—Indianapolis
Eisaman, Cecil L.—Indianapolis
Engle, David E.—Indianapolis
Evans, Paul V.—Indianapolis
Everly, Ralph—Indianapolis
Farrell, J. T.—Indianapolis
Fausset, Calvin B.—Indianapolis
Felson, Benjamin—Indianapolis
Firestein, Ray—Indianapolis
Fitzgerald, Brice E.—Indianapolis
Flanigan, Meredith B.—Indianapolis
Flora, Joseph O.—Indianapolis
Gambill, William—Indianapolis
Garfield, Martin D.—Indianapolis
Garner, William S.—Indianapolis
Geider, Roy A.—Indianapolis
George, Charles L.—Indianapolis
Gillespie, Jacob E.—Indianapolis
Gosman, James H.—Indianapolis
Grisell, Ted—Indianapolis
Grove, Robert Houston—Indianapolis
Hadley, David—Indianapolis
Hall, Bernard R.—Indianapolis
Hallam, F. T.—Indianapolis
Harvey, Bennett B.—Indianapolis
Hash, John S.—Indianapolis
Hepburn, Charles K.—Indianapolis
Hippensteel, Russell—Indianapolis
Hummel, Russell Miller—Indianapolis
Humphreys, Joe E.—Indianapolis
Hurt, Laverne B.—Indianapolis
Hynes, Roy T.—Indianapolis
Johnson, Thomas W.—Indianapolis
Jones, Francis P.—Indianapolis
Kabel, Robert N.—Indianapolis
Kauffman, Sidney—Indianapolis
Kraft, Bennett—Indianapolis
Kwitney, Isadore J.—Indianapolis
Leser, Ralph U.—Indianapolis
Levi, Leon—Indianapolis
Lichtenberg, Melvin—Indianapolis
Loomis, Norman S.—Indianapolis
Mantz, Theodore P.—Indianapolis
Marshall, Albert L.—Indianapolis
Martin, Loren H.—Indianapolis
Matthew, William B.—Indianapolis
McCormick, C. O., Jr.—Indianapolis
McCoy, George A.—Indianapolis
McIntyre, James M.—Indianapolis
Melloh, Ardis F.—Indianapolis
Mendenhall, Clarence D.—Indianapolis
Mericle, Earl William—Indianapolis
Miller, David—Indianapolis
Miller, Ray D.—Indianapolis
Morris, Marion H.—Indianapolis
Muller, Lullus P.—Indianapolis
Nestmann, Ralph H.—Indianapolis
Nonte, Leo R.—Indianapolis
Norwick, Sydney S.—Indianapolis
Parker, John F.—Indianapolis
Quigley, Joseph B.—Indianapolis
Rabb, Harry S.—Indianapolis
Ramsey, Frank B.—Indianapolis
Romberger, Floyd T., Jr.—Indianapolis
Rosenak, Bernard D.—Indianapolis
Rothrock, Philip W.—Indianapolis
Rossman, William B.—Charleston, W. Virginia
Rubin, Milton M.—Indianapolis
Rust, Byron K.—Indianapolis
Ryan, Glenn V.—Indianapolis
Sicks, Okla W.—Indianapolis
Sedam, Herbert L.—Indianapolis
Shuler, Lacey L.—Indianapolis
Smith, David L.—Indianapolis
Smith, E. Rogers—Indianapolis
Smith, Lawson F.—Indianapolis
Smith, Roy L.—Indianapolis
Stanley, John S.—Indianapolis
Steele, Brandt F.—Indianapolis
Stevens, Sydney L.—Indianapolis
Stoeffler, Walter—Indianapolis
Stone, David F.—Indianapolis
Talbott, Dan E.—Indianapolis
Taylor, C. C.—Indianapolis
Taylor, Frederick W.—Indianapolis
Thompson, C. F.—Indianapolis
Torrella, J. A.—Indianapolis
Voyles, Glenn Q.—Indianapolis
Walker, James S.—Indianapolis
Warfel, Fred C.—Indianapolis
Whitlock, Francis C.—Indianapolis
Wilmore, Ralph C.—Indianapolis
Wilson, O. R.—Indianapolis
Wolfram, Donald J.—Indianapolis
Wood, Donald E.—Indianapolis
Wyttenbach, John E.—Indianapolis

MIAMI COUNTY

Barnett, Ralph E.—Peru
Berkebile, J. B.—Peru
Eikenberry, H. W.—Peru
Malott, Frederick R.—Converse
Sennett, William K.—Macy

MONROE COUNTY

Baxter, Neal—Bloomington
Marchant, Clarence H.—Bloomington
Owen, A. M.—Bloomington
Ramsey, Hugh S.—Bloomington
Reed, William C.—Bloomington
Speas, Robert C.—Bloomington
Topolgus, James N.—Bloomington

MONTGOMERY COUNTY

Kirtley, James Marion—Crawfordsville
Peacock, Norman F.—Crawfordsville
Pierson, Robert H.—Crawfordsville
Sharp, John L.—Crawfordsville
Wallace, H. C.—Crawfordsville

MORGAN COUNTY

Comer, Kenneth E.—Mooresville
Karpel, Bernard—Mooresville
White, Harvey C.—Martinsville

NOBLE COUNTY

Shortz, Gerald—Kendallville

ORANGE COUNTY

Dillinger, George R.—French Lick
Hammond, Keith—Paoli
Keseric, N. E.—French Lick
Sugarman, B. E.—French Lick

PARKE-VERMILLION COUNTY

Bloomer, Richard S.—Rockville
Rosenfeld, Norman B.—Clinton

PIKE COUNTY
McNaughton, L. M.____Petersburg
Widmeyer, Chester P.__Winslow

PORTER COUNTY
Brown, James C.____Valparaiso
Radivojevic, Sava M.__Valparaiso

POSEY COUNTY
Oliphant, Frank W.____Mount Vernon
Ropp, Harold E._____New Harmony

PULASKI COUNTY
Halleck, Harold J._____Winamac
Sennett, William K.____Winamac

PUTNAM COUNTY
Dettloff, Frederick____Greencastle
Fuson, W. J._____Greencastle
Johnson, James B.____Greencastle
Steele, Dick J._____Greencastle

RANDOLPH COUNTY
Slick, Crystal R._____Lynn

RIPLEY COUNTY
McConnell, William C.__Sunman

RUSH COUNTY
Dean, Donald I._____Rushville
Johnson, Robert B.____Rushville

ST. JOSEPH COUNTY
Berke, Robert D._____South Bend
Colip, George D._____South Bend
Culbertson, Carl S.____South Bend
Dietl, Ernest Lawrence_South Bend
Firestein, Ben Z._____South Bend
Gates, George E._____South Bend
Grillo, Donald_____South Bend
Holdeman, Richard W._South Bend
Langenbahn, Carl J.___South Bend
Libnoch, Casimir L.____South Bend
McDonald, Ralph M.___South Bend
Nelson, Raymond_____South Bend
Rudolph, Carl J._____South Bend
Sandoz, Harry Hall____South Bend
Schuknecht, Harold F._Mishawaka
Slominski, Harry H.___South Bend
Traver, Perry C._____South Bend
Ward, James W._____Mishawaka
Whitlock, Merle E.____Mishawaka

SHELBY COUNTY
Silbert, David B._____Shelbyville
Tindall, William R.____Shelbyville
Wilson, O. R._____Shelbyville

STARKE COUNTY
Matthew, John R._____Knox

STEUBEN COUNTY
Crum, M. M._____Angola

TIPPECANOE COUNTY
Ash, Harold H._____West Lafayette
Donahue, George R.___Lafayette
Dubois, Ramon B.____Lafayette
Flack, Russell A._____Lafayette
Harvey, B. J._____Lafayette
Lynch, Otis R._____Marengo
Marsh, George W._____Lafayette
McKinney, Daniel H.___Lafayette
Peyton, Frank W._____Lafayette
Rommel, Clarence H.___Lafayette
Stoen, Harold J._____Lafayette
Washburn, W. W._____Lafayette
Younan, Tom_____Lafayette

TIPTON COUNTY
Carter, Jean Val_____Tipton
Gossard, Meredith B.___Tipton

VANDERBURGH COUNTY
Adler, Raymond N.____Evansville
Alexander, John E.____Evansville
Cassidy, John L._____Evansville
Clements, Albert Fred_Evansville
Clouse, Paul A._____Evansville
Combs, Herman T.____Evansville
Davidson, William D.__Evansville
Dieckman, H. S._____Evansville
Durkee, Melvin S._____Evansville
Dyer, Wallace K._____Evansville
Faul, Henry J._____Evansville
Fickas, Dallas_____Evansville
Hart, L. Paul_____Evansville
Hartz, F. Minton_____Evansville
Laubscher, Clarence A. Evansville
Leich, Charles F._____Evansville
Mason, E. E._____Evansville
McCool, Joseph H.____Evansville
Miller, Robert J._____Evansville
Richey, Clifford O.____Evansville
Schneider, Charles P.__Evansville
Trockman, Richard J.__Evansville
Zimmerman, Harold___Evansville

VIGO COUNTY
Anderson, Walter C.___Terre Haute
Combs, Stuart R._____Terre Haute
Kreible, William W.___Terre Haute
Mahoney, Charles L.___Terre Haute
White, James V._____Terre Haute
Wilson, Fred L._____Terre Haute
Zwerner, Paul F._____Terre Haute

WABASH COUNTY
Pearson, William E.___Wabash
Rhamey, Arthur P.____Wabash

WARRICK COUNTY
Stover, Wendell C.____Boonville
Zwickel, Ralph E._____Newburgh

WASHINGTON COUNTY
Allen, Fred K._____Fredericksburg
Colglazier, Donald L.__Salem

WAYNE-UNION COUNTY
Ake, Loren F._____Cambridge City
Barton, Willoughby M._Centerville
Daggy, Benjamin T.___Richmond
Dingle, Paul_____Richmond
Kenyon, Charles E.____Cambridge City
Lewis, James F._____Liberty
Malcolm, Russell_____Richmond
Meredith, Elwood J.___Richmond
Stamper, L. Allen_____Richmond
Vance, William C.____Richmond

WELLS COUNTY
Dorrance, Thomas O.__Bluffton

WHITE COUNTY
Carney, John C._____Monticello
Morris, Warren Victor_Monticello

WHITLEY COUNTY
Heritier, Claude Jules_Columbia City
Lehmberg, Otto F._____Columbia City

ABSTRACTS

NEW DRUG FOUND EFFECTIVE IN TREATING HYPERTHYROIDISM

A new drug, thiobarbital, has been found effective in the treatment of hyperthyroidism, according to Elmer C. Bartels, M.D., of the Department of Internal Medicine at the Lahey Clinic, Boston.

Writing in the December 1 issue of *The Journal of the American Medical Association*, Dr. Bartels said that thiobarbital, in small doses, has apparently twelve times the effect of thiouracil, one of a new group of substances with the power to decrease thyroid toxicity. The action of the drug brings the basal metabolic rate to normal and slows the heart beat.

The author stated that "twenty-eight patients with hyperthyroidism have received thiobarbital, and definite and satisfactory antithyroid response was obtained in all." Previously thiouracil, although not proved to be a curative, was used effectively to improve the condition of severely sick patients before an operation was performed.

Dr. Bartels said that the "opportune moment for our initial trial use of thiobarbital came in October, 1944, when a patient receiving thiouracil developed a fever reaction necessitating discontinuance of treatment and in whom further antithyroid therapy was thought essential before thyroidectomy."

The most effective results with thiobarbital have been obtained with the treatment of patients who were unable to tolerate thiouracil, the author said. "Of nine patients in whom toxic reactions to thiouracil developed, seven tolerated thiobarbital, accomplishing complete relief of hyperthyroidism."

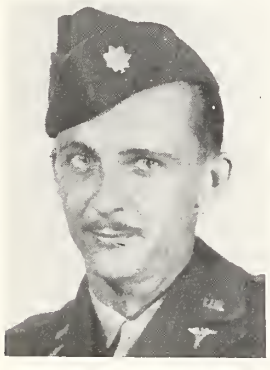
Although response to treatment was found to be similar in every respect to that observed with thiouracil, experience has shown, Dr. Bartels said, a high frequency of reactions to thiobarbital.

Military News

MAJOR THOMAS H. HEWLETT RETURNS FOLLOWING JAPANESE IMPRISONMENT

We know of not greater pleasure than to be able to report that another of our physicians has returned home after long years of imprisonment by the Japanese. To Major Thomas H. Hewlett we extend our heartiest "welcome home."

He graduated from the University of Louisville in 1938, interned at St. Edward's Hospital, in New Albany, and was associated with Dr. William H. Garner in the practice of general surgery at New Albany at the time of his call to active duty on October 7, 1940.



Major Thomas H. Hewlett

The story of his internment follows, just as Major Hewlett related it to us:

"Until April 17, 1941, I served on the surgical service of the Station Hospital at Fort Knox, Kentucky, arriving in Manila on May eighth, to be assigned to the surgical service of the Station Hospital at Fort Mills, Corregidor. At the outbreak of the war I was serving as chief of the Orthopedic Section and continued in this capacity throughout the period.

"Following the removal of the hospital and medical personnel to Manila in July, 1942, I remained on Corregidor as senior medical officer of a Jap ordnance prison camp of five hundred men. During the year following the surrender our unit cared for all the prisoners held on the fortified islands in Manila Bay. The care included major surgery. Our supplies were limited to what we could salvage from several aid stations on the Rock, and the Tunnel Hospital, the greater part of our supplies having been moved to Manila by the Japs about the time the patients were transferred. June and July of 1943 I spent in Bilibid Prison and at Cabanatuan, sailing for Japan on July 23, 1943, as senior medical officer assigned to a labor detail of five hundred men. We reached Japan on August 10, 1943, the trip being typical of those made on a Jap prison ship. We lost one ship out of the convoy as a result of an attacking submarine. We were forced to perform an appendectomy aboard ship in Takao, Formosa, as the Japs refused to take the patient ashore for the operation. In Japan I was placed in Camp No. 17 of the Fukuoka District, a coal mining camp situated in Omura, Island of Kyushu, directly across the bay from Nagasaki. During a period of two years the camp increased in size from five hundred to eighteen hundred. The food was always a starvation ration, and five men were executed during the time for minor offenses. I was permitted to run a hospital in the camp area. We ran a daily hospital census of about two-hundred-fifty men, treating one to two hundred men on a quarters' status because of lack of hospital space.

"Then on July 27, 1945, six of our ward buildings were destroyed during an incendiary raid. We were under almost constant air attack during the summer, and the Japs had difficulty keeping the prisoners from standing out in the open and cheering the attacking planes. We watched the sky effects from the atomic bomb dropped on Nagasaki, and although we didn't know what it was, we knew that it was far more powerful than we had ever seen before, having been exposed to both Japanese and American air power. It had been rather obvious to those of us in Camp No. 17 that Japan was ready to quit all summer—even the guards would ask us why the Americans didn't land and get the war over with, but in spite of our optimism most of the men did not expect to live to see the finish, for we faced starvation, destruction by air attack, and machine gun pits which had been prepared so that prisoners could be wiped out in case of an attempt on the adjacent beach. Our first knowledge of surrender came on the fifteenth of August, when all work ceased, and for the first time the camp commander issued Red Cross food packages and long-needed medical supplies to us. He announced the official cessation of hostilities on the eighteenth.

"We evacuated our patients to the hospital ship, the *U.S.S. Haven*, in Nagasaki, on the fifteenth of September. I remained aboard the *Haven* until it reached Okinawa, going from there to Manila by air, arriving in San Francisco via plane in October. Medical officers of my acquaintance never ceased to marvel at the unbelievable ignorance and crudeness of the Japanese army and civilian doctors, and we found that even in Japan the soldiers and the civilians preferred treatment by an American."

On August seventeenth Major Hewlett, then a captain but promoted to major on September second, was honored by the presentation of a certificate signed by the Allied Medical Officers of Camp No. 17, including two American, one Dutch, and two Australian officers. The certificate reads as follows:

"It is with much pleasure that we, the undersigned doctors in the Medical Department of the Fukuoka Prison Camp No. 17, with Captain Thomas H. Hewlett, of the United States Army Medical

Corps as senior medical officer, are able to state that Doctor Hewlett has throughout this extremely difficult period set a standard of high professional work. His sound technical knowledge and ability is reflected in the excellent results obtained in this camp, the population of which reached 1,992 over a period of two years. Eighty per cent of these men were engaged in such hazardous occupations as coal mining, foundry work, and dock work, some of the men being exposed to severe climatic conditions. His advice has been available to all, and his own personal example and leadership has encouraged us all to further efforts.

"We believe that as a result of his efforts on behalf of the sick in the camp Captain Hewlett at one time spent a period of solitary confinement in the guardhouse."

Doctor Hewlett is returning to practice in New Albany, again to be associated with Dr. Garner.

After fifty-eight months of service in the Army Medical Corps, Dr. Gordon A. Dickinson has returned to Petersburg. Dr. Dickinson served with the rank of Captain.

Dr. Robert M. Butterfield, of Muncie, recently returned to his practice there, after serving as a captain for twenty-seven months with the Army Medical Corps in the South Pacific.

Dr. Sydney L. Stevens, of Indianapolis, has entered private practice in Indianapolis, following his release from the armed forces. He served with the rank of lieutenant colonel, and was in service approximately five years, nine months of which were spent overseas.

Recently discharged from the Medical Corps, Dr. Stuart R. Combs, of Terre Haute, has set up practice in the Tribune Building there. He served overseas with a Field Hospital Unit, and had been in service since June, 1942.

Formerly a captain in the Army Medical Corps, Dr. Harold Nugen, of Auburn, recently received his discharge. He was in the service three and one-half years, most of the time being spent in the South Pacific.

After having been awarded the Bronze Star Medal for meritorious service in the Rhineland campaign, Dr. Robert L. Armington, of Anderson, has received an honorable discharge from the Medical Corps. Captain Armington was in the service thirty-seven months and plans to resume his practice in Anderson.

Dr. Harry S. Rabb, of Indianapolis, has reopened his offices after three years in the European Theatre. Doctor Rabb was on duty as flight surgeon in England, France, Belgium, and Germany, and had earned four campaign stars when the war ended. He served with the rank of major.

Major Frank G. Sink, of Remington, recently received his release from the Medical Corps after serving more than four years in the Army.

Announcement has been made of Dr. Donald Grillo's resumption of practice in South Bend, after active military duty. Dr. Grillo served with the rank of major.

Lloyd E. Rosenbaum, M.D., of Anderson, has been discharged after thirty-one months overseas. Doctor Rosenbaum was first stationed in North Africa for about a year, but also served in Sardinia, Italy, France, and Germany. He plans to resume practice soon.

The division to which Major Keith Hammond, of Paoli, is attached, was expected to be released from the European Occupation Zone the first of November. He expects to resume his medical practice in Paoli.

After a short vacation, Captain John Birdzell, of Crown Point, plans to begin the practice of medicine with his associates, Dr. John Iddings and Dr. E. B. Steele. Dr. Birdzell recently was discharged from the Separation Center at Camp Atterbury, after his return from England.

We wish to quote excerpts from a letter written by Captain J. Neill Garber, of Indianapolis, while he was stationed with the 47th General Hospital on Luzon:

"Momentous news of the moment is that our outfit will be at sea bound for Japan in the next two days. Wheels are actually beginning to turn after what seems to have been a long wait.

"It is encouraging to learn that you people are exerting all influence and effort to do what you can about getting people home. I believe that troop return is going along more quickly from Japan than from here at present."

Lieutenant Colonel John H. Greist spent a short leave in Indianapolis in November. He is on duty with the headquarters of the Seventh Service Command at Omaha, Nebraska.

With the 54th General Hospital in Tokyo, Major Hugh K. Thatcher, Jr., of Indianapolis, is assisting in setting up the American Memorial Hospital. This hospital was built with American funds in 1923, following the earthquake.

Recent announcement has been made of the opening of an office in North Judson by Dr. John R. Matthew, formerly of Knox. Dr. Matthew recently received his discharge from service in the Army Medical Corps, having served as a captain in the European Theatre for ten months.

After two years overseas' service with a medical combat team, Major Nicholas W. Hatfield has returned to Indianapolis to re-establish his practice. Major Hatfield served in Australia, New Guinea, the Philippines, and Japan. He wears the Purple Heart, the Silver Star Medal, and four battle stars.

William C. Reed, M.D., of Bloomington, has returned to Bloomington after serving as a lieutenant colonel in the Army Medical Corps. Doctor Reed was stationed for the most part at Camp Shelby, Mississippi, where he was post surgeon.

Announcement has been made by Dr. Jesse S. Spangler, of Kokomo, that he has reopened his office there, as of December first, following his release from active duty in the armed forces. Dr. Spangler carried the rank of lieutenant commander.

Effective as of October first, Dr. Wallace D. Buchanan, of Bremen, has been promoted to lieutenant commander in the United States Navy. Commander Buchanan is stationed at the Naval Hospital at Portsmouth, Virginia.

Dr. L. N. Kirch will enter a residency at the Indianapolis City Hospital, following his recent discharge from service. Serving as a captain in the Medical Corps, he spent almost two and one-half years in Africa and Italy.

Recently discharged as lieutenant commander in the USNR, Dr. Russell W. Wood has resumed his practice at Oakland City. Dr. Wood spent nineteen months in the South Pacific with the Seabees prior to being stationed in New Orleans, where he has been for the past year.

Following his return from France in September, Captain John S. Schechter, of Indianapolis, has been stationed at the Regional Hospital at Camp Bowie, Texas.

Dr. Melvin Lichtenberg, who served forty months in the Army Medical Corps, has returned to Indianapolis. His service includes twenty-eight months overseas' duty, in Australia, New Guinea, the Admiralties, Leyte and Cebu in the Philippines, and Honshu, Japan, with the Army of Occupation.

Dr. Charles L. Richardson, of Rochester, has resumed practice there, following his recent discharge from the service, where he served as a major.

By appointment of the mayor, Dr. Harry H. Slominski, of South Bend, has resumed his duties as city physician. He left the position several years ago to serve in the United States Navy, where he carried the rank of lieutenant commander.

Announcement has been made by Major General Paul R. Hawley, Acting Surgeon General, Washington, D. C., of the appointment of Lieutenant Colonel Donald A. Covalt, of Muncie, as director of a Veterans Administration program designed to speed the rehabilitation of disabled veterans.

Recently discharged from the Army, after serving three and one-half years in the Medical Department of the Aviation Corps, Dr. Donald Reed, of Culver, announces that he has resumed practice at his former location, in Culver. He carried the rank of captain in the service.

Following nearly five years in service, two years of which were spent overseas, Dr. Frank B. Ramsey, of Indianapolis, is taking a refresher course in general surgery at the Lahey Clinic in Boston. He plans to resume his practice in Indianapolis the first of the year. Dr. Ramsey was a lieutenant colonel and served with the 38th Division.

Dr. James M. Pfeifer, of Lawrenceburg, has informed us that he was separated from service on November tenth, and expects to return to practice by the first of February. He served as a captain in the Medical Corps.

Morris C. Snyder, M.D., formerly with the Indianapolis Methodist Hospital, entered service in June, 1942. He served in Germany, with the Third Army, being overseas nineteen months. Doctor Snyder was on duty as a major in the shock ward of the 109th Evacuation Hospital. He is planning to enter private practice in Richmond.

After three and one-half years in the service, Captain Jack McKittrick, of Washington, has been discharged. He recently returned from twenty-eight months' overseas as flight surgeon with the Eighth Air Force, based in England.

Announcement has been made of the return to private practice of Dr. David B. Silbert, of Shelbyville. A captain in the Medical Corps of the United States Army, Dr. Silbert served in France and Germany with the 61st Signal Battalion.

Another Indianapolis physician who has reopened his office following discharge from the service is Dr. Dan E. Talbott, who spent twenty months in the Pacific Theatre, having been in the service more than three years as a major. He specializes in obstetrics.

Dr. Norman B. Rosenfeld, formerly of St. Louis, Missouri, has taken over the practice recently vacated by Dr. James W. Frazier, in Clinton. Dr. Rosenfeld was discharged recently from the Army Medical Corps, where he held the rank of major. Dr. Frazier is moving to Wisconsin.

Dr. James S. Walker, of Indianapolis, plans to leave after the first of the year for Johns Hopkins University, where he has a Rockefeller Fellowship in the Ear, Nose and Throat Department. Dr. Walker recently returned home from service, after spending thirty-nine months in the Southwest Pacific, with the rank of captain.

Captain W. D. C. Day has been released from active duty with the Navy Medical Corps, and expects to resume his practice in Seymour in the near future. Captain Day entered the service in April, 1941, and served with the Marine Corps until 1944, when he was assigned to sea duty with the Pacific Fleet.

Dr. John E. Wyttenbach, of Indianapolis, has returned to private practice in Indianapolis, following his recent discharge from the Army Medical Corps after five years' service. Dr. Wyttenbach had served as executive officer of the 173rd General Hospital in Nancy, France, and commanding officer of the Sixth Field Hospital in England. He carried the rank of lieutenant colonel.

Now on terminal leave, Major William Deutsch plans to resume practice in Muncie. Entering the Army in May, 1942, Major Deutsch spent two years overseas in Africa and Corsica. He returned to Billings General Hospital, Fort Benjamin Harrison, in October, 1944, where he served as chief of the E.E.N.T. service until he received his discharge. Major Deutsch wears a battle star on his E.T.O. ribbon for his participation in the Italian campaign.

Major Marion Morris, of Indianapolis, has been discharged after one and one-half years' service in the European Theatre.

Dr. Ralph V. Everly has resumed the practice of medicine in Indianapolis, following his recent discharge from service. Dr. Everly carried the rank of captain, and was in service approximately three years, more than two of which were spent overseas —England, France, and Belgium. He wears seven battle stars and a Bronze Star Medal.

Another Indianapolis physician who has returned to practice is Dr. Murray DeArmond. He entered the service in 1941 and organized the neuropsychiatric service in the five-thousand bed convalescent hospital at Camp Pickett, Virginia, where he served as consultant until its close in October, with the rank of lieutenant colonel.

Another Indianapolis surgeon who has been released from service is Dr. O. W. Sicks. After more than three years of service with the Army Medical Corps, the last six months as chief of surgery at the 308th General Hospital, on Tinian, he was released recently, with the rank of lieutenant colonel.

Dr. Harry L. Kahan, of Gary, has resumed his practice there, having been released from service with the Army Medical Corps recently. Major Kahan spent practically a year overseas with a hospital unit in England, after helping set up the hospital at Camp Atterbury.

After serving for thirty-eight months in the Army Medical Corps as a captain, Dr. Charles L. George has reopened his office in Indianapolis for the practice of medicine. Twenty-six months were spent overseas with the Fifty-eighth Evacuation Hospital, with which he participated in the Admiralty Islands, Leyte, and Cebu campaigns, and in the occupation of Japan.

Major Warren V. Morris, of Monticello, now on terminal leave after twenty-six months in the European Theatre of Operations, plans to resume practice in Monticello. Major Morris was in charge of a clearing company with the First Army. He was stationed in England for nine months, going into France on June 8, 1944.

After twenty months' service overseas, Dr. George E. Scott is now home on three months' terminal leave. Doctor Scott was formerly at Frankfort, but now resides in Hartford City. He was on duty with the 23rd Field Hospital in New Guinea, and was in the invasion of Lingayen in the Philippines. He returned to the United States in July.

After three years' service in the Medical Corps, from which he was recently discharged, Dr. Robert H. Pierson, formerly of Spencer, has opened an office in Crawfordsville.

Another veteran of the Southwest Pacific, Dr. Oliver R. Wilson, of Indianapolis, has opened an office there for the practice of general medicine. Captain Wilson saw service in the Christmas Islands and Okinawa, having served overseas for thirty-nine months.

Dr. Claude Jules Heritier is spending his terminal leave in Columbia City. After one year's service overseas, most of which time was spent at Stuttgart, Germany, Doctor Heritier returned on November twenty-fourth. He was a battalion surgeon in the Field Artillery, and wears a bronze star and the Purple Heart. He plans to resume practice in Indiana.

After almost five years' absence, Dr. John Lansford, of Redkey, has reopened his office. Doctor Lansford was inducted in January, 1941, and was a lieutenant colonel at the time of his discharge. He spent thirty-one months in the New Guinea and Australian areas, and prior to his release was medical inspector at the Harmon General Hospital, at Longview, Texas.

Captain James L. Lamey, and his brother, Lieutenant Commander Paul T. Lamey, have received discharges and returned to Anderson. Dr. James Lamey served in the Pacific Theatre for twenty-eight months, and in the States for the past year, and Dr. Paul T. Lamey served two years in the Atlantic Theatre on board the *U.S.S. Wyoming*, and has been stationed at the Naval Hospital at Corvallis, Washington, for the past year.

Formerly of Peru, Dr. H. Wilson Eikenberry has recently returned from overseas' service in the Army Medical Corps, and has relocated in Indianapolis. Major Eikenberry was overseas twenty months, having served with the 60th Troop Carrier Group in Africa, Sicily, Italy, France, and England. After V-E Day he was assigned to Trinidad, where he was attached to the A.T.C., whose project was to fly personnel of the Fifth Army back to the United States.

On October twentieth Colonel J. W. Duckworth, who practiced in Indianapolis prior to joining the Army in 1917, assumed command of the Lawson General Hospital, at Atlanta, Georgia. Colonel Duckworth was commanding officer of a hospital unit prior to the fall of Bataan and retained administrative control of the unit the first year of his imprisonment in the Cabanatuan Prison Camp, in the Philippines. Following his release in September, 1944, he assumed command of the Winter General Hospital, in Topeka, Kansas, where he was stationed until his present reassignment.

Dr. Arthur P. Echternacht, formerly of Indianapolis, is to be associated with Dr. Wemple Dodds, at Crawfordsville, according to a recent announcement. He has been in charge of the X-ray and Radium Department at the Indiana Medical Center, and assistant professor of Radiology at the Indiana University School of Medicine.

Dr. Wendell C. Kelly, formerly of Indianapolis, has opened an office at Anderson, upon his recent release from the armed forces, in which he served the past four years, being overseas for two years. Major Kelly served with the 36th General, a Wayne University unit, in Africa, Italy, France and Germany.

Dr. J. M. Kirtley, of Crawfordsville, has reopened his office there, after his recent return to inactive status. Major Kirtley spent more than four years in the service, having gone overseas as the regional surgeon of the 22nd Infantry Division. His Division was the first to enter Paris, and later went into Germany.

Commander A. F. Clements has been discharged and has returned to Evansville to resume his E.E.N.T. practice. For eighteen months he served on a hospital ship in the Pacific Theatre, participating in the campaigns in the Gilbert, Marshall, Marianas, and Palau Islands. For the past six months he has been stationed at Kings Point, New York, and has a total of thirty-five months' service to his credit.

Captain D. E. Storey, of Indianapolis, has returned to Indianapolis. Captain Storey went overseas with the 643rd Medical Clearing Company in 1943, becoming commander of this unit on V-E Day. He landed in South Wales; then England; took part in the Normandy invasion; then joined the Ninth Army which went into Holland, and made the assault crossing of the Rhine; and he reports that they were the first medical unit in Berlin, "in spite of the fact that many others make the same claim." He is now on terminal leave, and reports that his future plans are indefinite.

Another Terre Haute physician, who has been released from service and resumed his practice there, is Dr. Edward C. Voges. Dr. Voges entered the Army Medical Corps in April, 1941, and, after being stationed at various hospitals in the United States, was sent to Oran, Algeria, in August, 1943, then to Naples, Italy, with the 32nd Field Hospital. This unit was assigned to General Mark Clark's 5th Army for the entire Italian campaign, and Dr. Voges served as commanding officer of a platoon, with the rank of major. He wears the Bronze Star Medal, and battle stars for the four battles of the Italian campaign.

Now on terminal leave, Captain John S. Stanley, formerly of East Chicago, has relocated in Indianapolis. Captain Stanley was flown from Paris to Billings General Hospital where he was under treatment for a time for an injury received in an accident while he was on detached service in Charleroi, Belgium. He was then transferred to Camp Atterbury on October fourteenth for discharge, after five years and seven days in the service.

Recently promoted to lieutenant commander, Commander Andrew M. Brenner, of Winchester, has also been promoted to Senior Medical Officer of Marine Corps Air Group 94 in the Marshall Islands. Commander Brenner is in charge of a complement of three thousand men. He has been on duty with the Navy for three years, spending the last year overseas. He flew in with his squadron to the invasion of Iwo Jima, and has been stationed since that time at Tinian in the Marianas and at Iwo Jima. As senior medical officer, Commander Brenner will fly throughout the Marshall and Gilbert Islands.

Dr. I. Winfield Scott has returned from service and is resuming his practice in pediatrics in Indianapolis. Doctor Scott was stationed in the China-Burma-India Theatre for many months. Upon his return to the United States he was sent to the Walter Reed General Hospital, where he served for nine months in the Out-Patient Department. He was then sent to sea, aboard the *U.S.S. Emily Weder*, a United States hospital ship. At that time another Indiana physician, Colonel Guy A. Owsley, of Hartford City, was the commanding officer of the ship. Colonel Owsley is now on duty at the Torrance Station Hospital, in California.

Dr. Alexander T. Ross, of Indianapolis, assistant professor of Neurology at the Indiana University School of Medicine prior to his entry in the Army Medical Corps, has been separated from service and is now associated with Dr. E. Rogers Smith, of Indianapolis, in the practice of neurology and psychiatry. Major Ross entered service on September 25, 1941, and was stationed at Billings General Hospital, Fort Benjamin Harrison, during the ensuing year. He then went to Camp Rucker, Alabama, and went overseas from there on January 6, 1943, with the 36th Station Hospital when it was activated. He was stationed at Exeter, England, until March, 1943, when he was transferred to the 298th General Hospital (University of Michigan Hospital) in Bristol. In February, 1944, he was transferred to the 96th General Hospital at Malvern, England, where he was chief of the Neurology Service. Then in June, 1945, Major Ross was ordered back to the United States to replace the chief of the Neurology Branch in the Office of the Surgeon General, in which capacity he functioned until December 14, 1945.

Captain John O. Butler, of Indianapolis, has been awarded the Silver Star for gallantry in action at Lohhof, Germany. Attached to the 20th Tank Battalion, Captain Butler directed the rescue of wounded men under heavy sniper fire. He and his wife, the former Dr. Martha L. Crandall, of Princeton, recently returned to Fort Lewis, Washington, after a thirty-day leave. Mrs. Butler is also a captain, and was the first woman physician in Indiana to enter service. She is stationed at Fort Lewis.

Major John L. Ferry of Whiting, Indiana, was head of the Division of Industrial Medicine for the Medical Section of the Manhattan Engineer District, the Army organization which supervised the production of the atomic bomb.

Major Ferry entered active duty as a captain on March 17, 1943, with the 32nd General Hospital, but was transferred on April 30, 1943, to the New York office of the Manhattan District. He was made assistant to the chief of the Medical Section, an organization which grew in time to include eighty-nine Medical Department officers, and was placed in charge of the industrial activities of the section, supervising an industrial hygiene program designed to protect the health of approximately fifty thousand workmen.

Production of the atomic bomb required work with little-known radioactive substances on a vast scale and necessitated careful supervision of both research and production workers. Major Ferry acted as consultant in industrial hygiene to manufacturers processing uranium and other special materials used. He instituted and supervised a laboratory of industrial hygiene to perform the special tests required by the unusual nature of the operations.

In addition he acted as liasion officer to a large medical research organization, to acquaint the scientists with the requirements of the industrial activities and to keep the contractors supplied with the most recent toxicity data. Major Ferry acted as consultant in writing a series of bulletins on safe-handling practices for special chemicals during the time he was stationed in New York.

On July 15, 1944, he was transferred to Oak Ridge, headquarters of the Manhattan District, and while continuing to function in the above-mentioned activities, he also supervised the industrial medical programs of the gas and thermal diffusion and the electromagnetic processes for the concentration of Uranium 235.

During the absence of Colonel Strafford L. Warren, chief of the Medical Section, to investigate the effects of atomic bombing in Japan, Major Ferry was appointed acting chief of the Medical Section. In a recent press release he was listed with forty-five other officers, among the several hundred assigned to the project, as one of the officers "who have made exemplary contributions to the success of the project."

News Notes

Dr. H. J. Halleck, of Winamac, has recently been appointed as county health officer, replacing Dr. R. J. Ives, of Francesville, who resigned.

Dr. Lillian G. Moulton, of Indianapolis, has left the State Department of Public Welfare and plans to enter private practice.

Dr. William A. Karsell, of Bloomington, who recently retired from active practice, has become connected with the Medical Department of Eli Lilly & Company, in Indianapolis.

Dr. J. William Wright has been chosen president of the Indianapolis Medical Society for 1947. Dr. E. Vernon Hahn is the incoming president for 1946, succeeding Dr. Cleon A. Nafe, outgoing president.

Announcement has been made by Dr. H. Frederick Streib that he will establish full-time practice in Portland. Formerly he maintained offices in Portland and Redkey, but henceforth he will confine his practice to Portland, where he and his family have located.

Dr. Herman G. Morgan, of Indianapolis, was recently honored by having the new Flanner House Health Center named for him, and was guest of honor at the annual Founders' Day dinner which was held December seventh in the new Flanner House. He was also chosen as "outstanding citizen" by the Flanner House Board of Directors for his unceasing efforts in its behalf. More than two hundred prominent Indianapolis physicians, social workers, city and state officials, state and local health authorities, and officials of the Community Fund and Council of Social Agencies attended the dinner.

THE SOUTHEASTERN SURGICAL CONGRESS

The Southeastern Surgical Congress will hold its next Assembly at Memphis, March 11, 12, 13, 1946, at the Peabody Hotel, and the medical profession is invited to attend this meeting. Following is a partial list of those who will take part in the program: Drs. Conrad G. Collins, New Orleans; Merrill N. Foote, Brooklyn; Clarence E. Gardner, Durham; James E. Hemphill, Charlotte; Robert Hingson, Jr., Staten Island; Arnold Jackson, Madison, Wisconsin; Roy R. Kracke, Birmingham; Karl A. Meyer, Chicago; J. O. Morgan, Gadsden, Alabama; Curtice Rosser, Dallas; Harold E. Simon, Birmingham; G. L. Simpson, Greenville, Kentucky; and Horace G. Smithy, Charleston, South Carolina. For information, write Dr. B. T. Beasley, Atlanta 3, Georgia.

Dr. M. F. Daubenheyer, of Butlerville, has been chosen to succeed Dr. O. R. Lynch as head of the Muscatatuck State School, at Butlerville. Dr. Lynch recently accepted the superintendency at the Richmond State Hospital.

At the House of Delegates' meeting of the A.M.A., held in Chicago early in December, Dr. Don F. Cameron, of Fort Wayne, was named on the Committee on Hygiene and Public Health, and Dr. F. S. Crockett, of Lafayette, was appointed to the Committee on Rules and Order of Business.

Dr. Martin F. Hanson and his wife, Dr. Anita Hanson, recently opened offices in Anderson. Dr. Anita Hanson is a graduate of the Ohio State University, and Dr. Martin Hanson is a graduate of the University of Illinois. He has recently been discharged from the Air Corps, and had practiced medicine and surgery in Illinois before entering the service.

The board of managers of the Irene Byron Sanatorium, Fort Wayne, recently announced the appointment of Dr. Orva T. Kidder of Fort Wayne, as assistant medical director. Recently released from the Medical Corps, where he held the rank of captain, Dr. Kidder participated in the African and Sicilian campaigns. He also served on the staff of the Crile Hospital at Cleveland.

CHICAGO MEDICAL SOCIETY MEETING

The Chicago Medical Society Annual Clinical Conference will be held at the Palmer House, Chicago, March 5, 6, 7, and 8, 1946. Outstanding members of the medical profession have been invited to present papers of general interest to the entire profession. This first major general meeting since the cessation of hostilities should prove extremely interesting to all physicians in and near Illinois.

A new surgery at Billings General Hospital, built at a cost of sixty thousand dollars, has been completed and formally opened by the commanding officer. Six operations may be performed simultaneously in the modernly-equipped operating cubicles, which are provided with concentrated light, and spark-proof electric outlets are installed throughout, guarding against explosion of ether and gas. Two anesthesia rooms, and modern dressing rooms and showers for surgeons are provided. The adjoining postoperative ward is set up in three-bed sections, with nurses' stations between them.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

Special Meeting, Indianapolis

December 16, 1945

The Council of the Indiana State Medical Association convened at 12:30 P.M., Sunday, December 16, 1945, in the Harrison Room of the Columbia Club, Indianapolis, for a special meeting, with Dr. A. M. Mitchell, chairman, presiding. The following were present:

Members of the Council:

Third District—A. P. Hauss, New Albany
Fourth District—Charles F. Overpeck, Greensburg
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—William H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison, South Bend

Officers:

N. K. Forster, Hammond, president.
J. E. Ferrell, Fortville, president-elect 1945.
F. T. Romberger, Lafayette, president-elect 1946.
E. M. Shanklin, Hammond, editor of THE JOURNAL.
C. A. Nafe, Indianapolis, chairman, Executive Committee.
C. H. McCaskey, Indianapolis, Executive Committee.
F. S. Crockett, Lafayette.
C. F. Thompson, Indianapolis, Veterans' Affairs Committee.
Albert Stump, Indianapolis, attorney.
T. A. Hendricks, executive secretary.
Ray E. Smith, assistant executive secretary.

ASSOCIATE EDITOR OF THE JOURNAL

Dr. Shanklin asked that the selection of an associate editor of THE JOURNAL be deferred until the April meeting of the Council. He called the attention of the Council to the fact that printing costs will be greatly increased in 1946. The per page rate in 1946 will be $10.80 as against $6.75 in 1945, an increase of approximately 60 per cent, with an additional charge of $3.50 per hour for undue alterations in copy after it has been typeset.

STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION

The Council adopted the following resolution and instructed that it be presented to the proper authorities:

"WHEREAS, The Indiana State Legislature during its 1945 session passed a law providing for the practice of medicine by osteopathic physicians, under the same terms and conditions as apply to graduates of approved medical colleges, Therefore be it

"RESOLVED, That the Council of the Indiana State Medical Association petition the Indiana State Board of Medical Registration and Examination to adopt a resolution concerning the administration of this Act, in substance, as follows:

"WHEREAS it now becomes the duty of the Indiana State Board of Medical Registration and Examination to administer the afore-mentioned Law, House Bill No. 176 of the Acts of 1945, whereby osteopathic physicians may be licensed to practice osteopathy, *medicine*, surgery, and obstetrics, on the same terms and conditions as those licensed to practice medicine, surgery and obstetrics, Therefore be it

"RESOLVED, That each and every applicant for a certificate to practice osteopathy, *medicine*, surgery, and obstetrics be required to have successfully passed an examination in materia medica in a medical school, approved by the Indiana State Board of Medical Registration and Examination, said examination having been successfully passed as a prerequisite to graduation from said approved medical school, before the applicant is admitted to examination before the Indiana State Board of Medical Registration and Examination."

SERVICEMEN'S RESOLUTION

The matter of working out details of the program proposed in the report of ex-medical officers, which was accepted by the House of Delegates at the French Lick meeting, was referred by the House to the Council. The chairman read this report, and each resolution was acted upon separately as follows:

"WHEREAS the problems of the medical officer returning to civilian practice or the completion of his graduate training at the time of separation from active duty present difficulties which only organized medicine as represented by the Indiana State Medical Association and the American Medical Association and their component parts can solve; and

"WHEREAS these problems are acute, requiring prompt action, Therefore be it

"(1) RESOLVED, That the House of Delegates of the Indiana State Medical Association establish a Servicemen's Section, the membership of which will consist of the men separted from service with the armed forces and registered at French Lick during the 1945 annual meeting and members of the American Medical Association in good standing who return to the State of Indiana and become members of the Indiana State Medical Association."

(Dr. Sparks made the motion that the servicemen have an official luncheon at the annual meeting, and a place to meet. Motion seconded by Dr. Clark, and carried.)

"(2) That the Committee on Postwar Medical Service of the Indiana State Medical Association provide a means of registration for medical officers returning from the armed services and a special service and information to such registrants through the Executive Office of the Indiana State Medical Association."

(Dr. Thompson announced that such registration exists now through the office of the Procurement and Assignment Service.)

"(3) That the County Committee on Procurement and Assignment Service in each county be responsible for prompt assistance in procuring adequate office space and residence for physicians returning to former locations from the armed forces."

(Dr. Clark made the motion that the chairman of the Procurement and Assignment Committee in each county be informed that it is his duty to give advice and assistance to servicemen seeking locations. Motion seconded by Dr. Black, and carried.)

"(4) That the Indiana State Medical Association establish a loan fund from its reserve fund or similar funds for the benefit of physicians returning from the armed services."

(Dr. Clark moved that a committee be appointed from the Council to work with Dr. Thompson and perhaps with Dr. Bird to see what should be done and what steps should be taken to get this loan fund in operation. Motion seconded by Dr. Howard, and carried. The chairman appointed Dr. Clark, Dr. Black, and Dr. Dodds on this committee.)

"(5) That the Postwar Medical Service Committee of the Indiana State Medical Association increase the facilities for completion of graduate training interrupted by service in the armed forces in institutions in the State of Indiana recognized by the American Medical Association by means of:

"(a) Assistant residencies financed according to provisions of the GI Bill of Rights and not increasing the budget of such institutions.

"(b) Supplement the residencies above by a schedule of assistancies in the offices of qualified physicians.

"(c) A plan to provide housing and adequate shelter for the families of physicians participating in such training."

(Dr. Forster reported that items "a" and "c" has been under consideration and taken care of by Dr. VanNuys' Committee on Postwar Medical Service. In regard to item "b," he suggested that the headquarters' office send out some inquiries and find out where physicians might need assistants. This suggestion was taken by consent.)

"(6) That a resolution be made to the Board of Trustees of the American Medical Association for civilian consultants to the medical services of the Army, the Navy, and the Veterans Administration for the purpose of providing maximum and efficient medical care to members of the armed forces at the time of war and to utilize the skill of medical officers to the greatest advantage by assignments according to the special training of such officers and distribution of medical officers in a manner to avoid the loss of such skill in replacement depots and officer pools."

(This resolution has been presented to the Board of Trustees of the American Medical Association.)

PREPAYMENT MEDICAL INSURANCE

The Committee on Insurance Plans, composed of Dr. W. U. Kennedy, Dr. Walter Portteus, and Dr. W. H. Howard, with Dr. F. S. Crockett as consultant, reported that with the aid of Mr. Stump they had prepared articles of incorporation, by-laws, and rules for both a mutual and a medically-owned stock company, as directed by the Council, and that because of a completely new arrangement offered by several nationally-known insurance companies and, presumably as a result of the recent message to Congress by the President, they were presenting another plan which provided for a medical agency owning and controlling the plan, but which provided for the employment of Blue Cross as a selling and collecting agency, and underwriting the financial responsibility in an old-line insurance company. The Committee pointed out that in each of the presented plans there was complete and assured compliance with the fundamentals deemed necessary by the committee.

These fundamentals were stated by the Committee to be: (1) the Indiana State Medical Association should in no manner assume any financial responsibility or liability, and should not, as an Association, participate directly in the conduct of the business; (2) that the plan should be of the non-profit type; (3) that the general policies, the fee schedules, and administration should at all times be completely under the control of medical men representing the organized profession; (4) that the adopted plan should be financially strong and actuarially sound, and its operations supervised by the state insurance department; and (5) that it should fit in with and be sold in conjunction with the Blue Cross hospitalization plan.

All the plans submitted complied with the listed requirements. The committee pointed out that the amounts to be paid out as indemnity had to be governed by the amounts collected in charges, and suggested that a basic indemnity schedule be adopted permitting a policy cost low enough to be available to the lowest income earners but with provision for optional policies paying higher indemnities for those able to pay larger policy costs. The committee recommended that the Council approve of the agency plan, which, while keeping complete control in medical hands, made unnecessary the creation of a new working organization; made unnecessary the subscription of large amounts of money by the profession; and eliminated financial responsibility and possibility of loss.

After discussion by the Council and explana-

tions of the workings of the present plans, Dr. Black made the following motion:

"I move that we adopt the agency-type indemnity plan and submit it to the House of Delegates for its approval, with the option of selecting a mutual indemnity plan." This motion was seconded by Dr. Overpeck, and carried.

Dr. Howard made the motion "That Dr. Kennedy write a letter on this proposition in simple language, specifically stating that the state association is in no way financially bound by this proposition, and that it be sent to every delegate in the state." Motion was duly seconded, and carried.

Dr. Clark moved that the House of Delegates meet at 1:00 P.M., Sunday, January 27, 1946, to consider this matter. This motion was taken by consent.

On the motion of Dr. Hauss the meeting was adjourned.

THOMAS A. HENDRICKS,
Executive Secretary.

EXECUTIVE COMMITTEE

September 30, 1945.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; N. K. Forster, M.D.; F. T. Romberger, M. D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; T. A. Hendricks, executive secretary; and Ray E. Smith, assistant executive secretary.

Luncheon meeting guests:

Colonel Earl H. Hare, chief medical officer, Veterans Hospital.

Bert C. Moore, manager, Veterans Hospital.

Charles R. Bird, M.D., chairman, War Participation Committee.

John D. VanNuys, M.D., chairman, Committee on Postwar Medical Service.

Leroy E. Burney, M.D., State Health Commissioner.

Louis W. Spolyar, M.D., director, Industrial Hygiene, State Board of Health.

Carl D. Martz, M.D., acting medical consultant, Vocational Rehabilitation, State Department of Education.

Membership Report

Number of members Sept. 30, 1945	3,361*
Number of members Sept. 30, 1944	3,345
Gain over last year	16
Number of members Dec. 31, 1944	3,400

* Includes 1,023 in military service and 140 honorary members.

The statements of receipts and expenditures for August for the association committees and THE JOURNAL were approved.

Treasurer's Office

The treasurer reported that he would submit a report on THE JOURNAL at the next meeting.

1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, November 6, 7, and 8, 1945

Indiana Health Officers' Association meeting Monday, November 6, 1945, at French Lick.

Program for annual session considered and time of events and meeting places established.

Commercial Exhibit:

Forty-two spaces sold to thirty-nine companies. Five companies canceled because of date change.

Scientific Exhibit: One exhibit from A. M. A., on "The Menace of the Rat."

House of Delegates:

(a) Special session on Prepayment Medical Plans set for 3:30 P.M., Tuesday, November 6.

(b) Honorary members must be voted on by House of Delegates, upon presentation of names by the local society, according to the By-laws, the attorney advised. The question of reducing the age from seventy-five to seventy was raised. The state headquarters was asked to survey the records and see how many more would be eligible if the age limit was reduced.

(c) The attorney reported that the House of Delegates has authority to add a Section on General Practice, and that no change in the By-laws is necessary. The last House of Delegates took such action, the president reported.

Distribution of Executive Committee Minutes: Part of report of Committee for the Study of Lay Activity in Medical Practice, asking that copies of the minutes of the state Executive Committee be sent at once to secretaries of local societies to be read, was discussed. Inasmuch as the minutes are printed in THE JOURNAL the committee saw no reason to change the present procedure.

Badges: A simple type badge was selected and the executive office authorized to receive bids and purchase them.

Banquet:

(a) Honorable Ralph F. Gates, Governor of Indiana, will deliver the principal address at the banquet.

(b) Motion was made by Dr. McCaskey, seconded by Dr. Romberger, that the Indiana presidents of the CIO, A. F. of L., and Farm Bureau be invited to the banquet. Dr. Forster moved, and Dr. Romberger seconded the motion, that the commander of the Indiana Department of the American Legion likewise be invited.

(e) Special table for the ex-presidents and their wives, the councilors and their wives, and the wives of those who are seated at the speakers' table will be arranged under the direction of Dr. Charles N. Combs.

Legislative, Legal and Social Security Matters

National

Wagner-Murray-Dingell bills in committee pending hearings beginning in December.

Senator Pepper's super EMIC bill is an important bill and may take precedent over the Wagner-Murray-Dingell bills.

Appointment of Watson B. Miller as Federal Security Administrator discussed by the executive secretary.

Prepayment Medical Plans

Report made that Committee on Prepayment of Medical and Surgical Care was going to recommend the adoption of the service plan to the House of Delegates.

Organization Matters

Editorial entitled "We Carried the Torch," by Robert S. Berghoff, M.D., president-elect of the Illinois State Medical Society, was distributed.

Question of state dues of two doctors in Public Health Service assigned to military units was referred to the Council, on motion of Dr. McCaskey, seconded by Dr. Romberger.

Program of Indiana Division, American Cancer Society, was discussed.

Copies of the educational program of the Oklahoma State Medical Association were distributed.

New 1945 state hospital licensing law was discussed by association attorney.

Memberships of physicians in military service will be continued on the same basis, pending change by the House of Delegates.

State Board of Health

Pre-employment physical examination plans of State Board of Health explained by Director of Industrial Hygiene.

State health commissioner reported plans for a survey of present hospital facilities and communities that need hospitals.

Report of Better Business Bureau

Copies of *Bulletin of Better Business Bureau*, on "Medical Quackery," were distributed.

War and Postwar Medicine

Suggestion was made that local societies ask for release of doctors on basis of community need.

A letter sent by the Michigan State Medical Society to members in military service was read. A similar letter from the Indiana State Medical Association was suggested.

Need of doctors in the Veterans Administration and schedule of fees were discussed by the manager and chief medical officers of Indianapolis Veterans Hospital.

Problems of getting doctors released from military service and getting those who are released to open offices in areas short of physicians were discussed by the chairman of the War Participation Committee.

Rehabilitation Program

Dr. Carl D. Martz, acting medical consultant of Vocational Rehabilitation, State Department of Education, reported on efforts being made to set up a program in Indiana under the state and federal laws.

Medical Economics

The tentative five-point program of Indiana Medical Care Committee of Indiana Farm Bureau was explained.

A report on the progress of the Committee on Postwar Medical Service was made by the chairman. Security fund for loans to returning veterans was suggested. On motion of Dr. Romberger, seconded by Dr. McCaskey, it was decided to send a letter to all members in military service, explaining opportunities for further education, etc., the letter to be similar to the Michigan letter and to be signed by the association president and members of the Executive Committee.

Future Medical Meetings

The Public Relations Conference at Chicago, October 19 and 20, 1945, is to be attended by Drs. Forster and Nafe. Motion was made by Dr. Romberger, seconded by Dr. McCaskey, that Ray Smith, assistant executive secretary, be instructed to attend. Motion carried.

An "Indiana Room" at the A. M. A. House of Delegates' meeting at the Palmer House, Chicago, December 3 to 6, was approved.

A. M. A. Secretaries' Conference postponed until February, 1946.

The Nineteenth annual meeting of the National Conference on Medical Service will be held in February, 1946, in Chicago, under the sponsorship of the Indiana State Medical Association. The Executive Committee of the conference will hold a meeting on December 2, 1945, to arrange for the annual conference.

Headquarters' Office

A committee composed of Drs. Nafe and Weyerbacher, and the executive secretary was appointed to confer with the Hume Mansur Company regarding headquarters' rent.

Fee schedule for attorneys. The matter of attorneys' fees for malpractice cases was discussed, and the attorney for the state association was asked to submit a new schedule of fees at the next meeting of the Executive Committee.

There being no further business the meeting was adjourned.

EXECUTIVE COMMITTEE

November 5, 1945.

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; N. K. Forster, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; E. M. Shanklin, M.D.; A. F. Weyerbacher, M.D.; R. L. Sensenich, M.D.; A. P. Hauss, M.D.; F. S. Crockett, M.D.; T. A. Hendricks, executive secretary; Albert Stump, attorney, and Ray E. Smith, assistant executive secretary.

(Continued on page xxx.)

Want better protection . . .

. . . Policy coverage is no better than the service by which it is administered.

for greater malpractice hazards?

. . . Prevailing unrest multiplies the dangers in every doctor's practice. His protection should therefore be more than good.

Use Specialized Service!

. . . Even if all policies were the same, Specialized Service would still put the "plus" in Medical Protective.

The Medical Protective Company

of

Fort Wayne, Indiana

(Continued from page 52.)

Membership Report

Number of members November 2, 1945 ..... 3,372*
Number of members November 2, 1944 3,383
Loss over last year 11
Number of members December 31, 1944 3,400
* Includes 1,023 in military service and 140 honorary members.

The committee decided that members returning from military service should be required to pay state dues for the remaining quarters of the year only, the quarter in which they return excepted, and that the date they resume private practice should be considered the time of their return. The executive secretary was directed to convey the committee's recommendation to the Council.

Treasurer's Office

On motion of Dr. Forster, seconded by Dr. McCaskey, it was voted to recommend to the Council that the $3,000 loaned to THE JOURNAL be transferred permanently from the Medical Defense Fund (from which it was originally taken) to THE JOURNAL account.

The statements of receipts and expenditures for September and October for the association committees and THE JOURNAL were approved.

Legislative, Legal and Social Security Matters

The death of Dr. Renos Richards, of Patricksburg, a member of the Indiana House of Representatives, was noted. A recommendation was made that the Legislative Committee endeavor to have his place in the House filled by another physician.

Prepayment Medical Plans

A letter from the State Nurses Association to Dr. W. U. Kennedy was read.

1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, November 6, 7, and 8, 1945

Dr. Hauss, co-chairman of the Committee on Convention Arrangements, gave a report of money already expended. A motion was made by Dr. McCaskey, seconded by Dr. Forster, and passed, allowing an extra two hundred dollars.

Commercial Exhibit:

Forty-four spaces were sold to forty-one companies.

1946 Annual Session

The executive secretary read a letter from the Indianapolis Convention and Publicity Bureau, inviting the association to meet in Indianapolis in 1946. He announced that the Fort Wayne (Allen County) Medical Society was going to extend a similar invitation.

Medical Economics

Approval (without motion) was given for a meeting of the Committee on Rural Medical Service of the Indiana State Farm Bureau and the Indiana State Medical Association Committee on Rural Medical Care.

Election of board members of the Indiana State Conference on Social Work was referred to Drs. VanNuys and Boggs.

A. M. A. Council on Medical Service and Public Relations

Dr. Nafe discussed in detail the recent conference of the Council on Medical Service and Public Relations, expressing the view that much had been accomplished.

Creation of Section on General Practice of A. M. A.

A letter from the Wayne County (Michigan) Medical Society was referred to Dr. Gatch for presentation before the House of Delegates.

Medical Defense

Fee schedule for attorneys: Motion was made by Dr. Forster, seconded by Dr. Ferrell, that attorneys' fees for malpractice suits be decided individually, upon the merits of each case, and that contracts with legal counsel be made upon that basis. The motion passed.

There being no further business the meeting was adjourned.

LOCAL SOCIETY REPORTS

100 PER CENT IN PAYMENT OF 1946 DUES

Carroll County
Clay County
Gibson County
Sullivan County
Whitley County

COUNTY MEDICAL SOCIETY OFFICERS

BOONE COUNTY MEDICAL SOCIETY
President, Charles O. Weddle, Lebanon
Vice-President, L. M. Headley, Lebanon
Secretary-treasurer, John R. Porter, Lebanon

CLARK COUNTY MEDICAL SOCIETY
President, Ralph W. Bruner, Jeffersonville
Vice-president, Sam Adair, Jeffersonville
Secretary-treasurer, Joel T. Carney, Jeffersonville

CLAY COUNTY MEDICAL SOCIETY
President, O. L. Wood, Brazil
Vice-President, R. K. Webster, Brazil
Secretary-treasurer, John M. Palm, Brazil

GIBSON COUNTY MEDICAL SOCIETY
President, H. F. Carpentier, Princeton
Vice-president, Edwin F. Marchand, Haubstadt
Secretary-treasurer, H. H. Alexander, Princeton

HOWARD COUNTY MEDICAL SOCIETY
President, D. W. Paris, Kokomo
Vice-President, Copeland C. Bowers, Kokomo
Secretary-treasurer, Joseph D. Boughman, Kokomo

HUNTINGTON COUNTY MEDICAL SOCIETY
President, R. S. Galbreath, Huntington
Vice-president, James R. Ware, Huntington
Secretary-treasurer, Grover M. Nie, Huntington

"Smoothage" IN THE CONSTIPATION OF PREGNANCY



The constipation frequently encountered during pregnancy, due to pressure of the fetus on the pelvic bowel, lack of exercise, and restricted diet, is alleviated by Metamucil.

The Smoothage of Metamucil encourages easy, gentle evacuation. It does not interfere with the absorption of vitamins or other food factors.

METAMUCIL *is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois*

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

"Smoothage" describes the gentle, nonirritating action of Metamucil—the highly refined mucilloid of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%).

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

LAKE COUNTY MEDICAL SOCIETY
President, Ray Elledge, Hammond
President-elect, David R. Johns, East Chicago
Secretary-treasurer, H. M. Baitinger, Gary

MADISON COUNTY MEDICAL SOCIETY
President, Sam Litzenberger, Anderson
Vice-president, C. V. Rozelle, Anderson
Secretary-treasurer, M. A. Austin, Anderson

SWITZERLAND COUNTY MEDICAL SOCIETY
President, G. W. Copeland, Vevay
Vice-president, Fred C. Bakes, Vevay
Secretary-treasurer, L. H. Bear, Vevay

WAYNE-UNION COUNTY MEDICAL SOCIETY
President, Elwood J. Meredith, Richmond
Vice-president, Charles E. Kenyon, Cambridge City
Secretary-treasurer, Harry P. Ross, Richmond

Allen County Medical Society members attended a meeting at the St. Joseph Hospital Nurses' Home, in Fort Wayne, December thirteenth, as guests of the Isaac Knapp Dental Society. Medical officers from Camp Atterbury were in charge of the program, which consisted of lantern slides and exhibits on surgery performed on war casualties.

* * *

Clay County Medical Society members met at the Clay County Hospital, in Brazil, on November twenty-seventh. Mr. Vernon Root, of the Blue Cross Insurance Company, addressed the group on the Blue Cross plan. Dr. Robert K. Webster presented a detailed paper on "The Proposed Plan for Improved Medical Care in Clay County," which was adopted as the official program for 1946. Major John M. Palm and Major O. L. Wood were welcomed back after four and one-half years' Army service.

* * *

Clark County Medical Society members met at Jeffersonville on December eleventh. Dr. Sam Adair, of Jeffersonville, spoke on his war experiences. Twelve members were present.

* * *

Elkhart County Medical Society members held their annual meeting for the election of officers on December sixth, at Hotel Elkhart, Elkhart. Dr. Jonathan Yoder, of Goshen, spoke on his experiences as a medical missionary in India. Forty-six members were present.

* * *

Floyd County Medical Society members held a meeting at the Frances Cafeteria, at New Albany, on December fourteenth. Dr. Francis W. Hetreed, of Chicago, a member of the United States Public Health Service, spoke on "Rapid Treatment for Syphilis." Sixteen members were present.

* * *

Fort Wayne (Allen County) Medical Society members met on December fourth at the Chamber of Commerce, Fort Wayne. Dr. R. Morton Bolman, Jr., of Chicago, was the guest speaker.

* * *

Gibson County Medical Society members met at the Gibson General Hospital, in Princeton, on December sixth. Organization and election of officers was the order of business. Sixteen members were present.

Huntington County Medical Society members held a meeting at Hotel Lafontaine, in Huntington, on December fourth. Reports of the councilor and delegate to the Indiana State Medical Association were read. Seventeen members attended the meeting.

* * *

Indianapolis (Marion County) Medical Society members held a meeting at the White Cross Service Center, Methodist Hospital, Indianapolis, November twenty-seventh. Dr. Lytle Atherton, of Louisville, Kentucky, was the guest speaker.

On December fourth they met at the White Cross Service Center. Annual election of officers was held, and reports of standing committees were read.

On December eighteenth Dr. Karl A. Meyer, of the Northwestern University Medical School, Chicago, was the guest speaker.

* * *

Jasper-Newton County Medical Society members held a meeting at the Jasper County Hospital, at Rensselaer, on November sixteenth. A welcome-back service for members of the armed forces was held, followed by election of officers. Eighteen members were in attendance.

* * *

Lake County Medical Society members held a business meeting September thirteenth, at Indiana University Extension Center, East Chicago. Forty members attended.

On October twenty-fourth the Lake County Medical Society and the Tenth District Medical Society held a joint meeting at the Gardiner General Hospital, in Chicago. The program was devoted to a discussion on the "Management of Chronic Osteomyelitis." An inspection of the hospital followed, and examination of actual cases relative to the subject discussed. One hundred thirty members attended.

At the November twentieth meeting of the Lake County Medical Society, which was held at the University Extension Center, East Chicago, Dr. Eric Oberg, of the University of Illinois Medical School, presented a paper on "Intervertebral Discs." Forty-five members were present.

The annual business meeting of the Lake County Medical Society members was held on December thirteenth, at the Woodmar Country Club, at Hammond. Officers were elected for 1946 and an inauguration of the new president, Dr. Ray Elledge, was held. One hundred thirty-nine members attended the meeting.

* * *

LaPorte County Medical Society members held a meeting on December twentieth, at LaPorte. Dr. Joseph Garrott Allen, of Chicago, spoke on "Blood Clotting and Thrombophlebitis."

Wyeth
REG. U. S. PAT. OFF.

Cascara Petrogalar

REG. U. S. PAT. OFF.



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Madison County Medical Society members held a meeting on December seventeenth, in Anderson. Dr. F. B. Wishard and Mr. Wayne Smith, of the Personnel Department of Delco-Remy, discussed their experience with the rehabilitation of returning veterans to industry. Thirty-two members were present.

* * *

Putnam County Medical Society members met at Greencastle on December thirteenth for a business meeting. Ten members were present.

* * *

St. Joseph County Medical Society members held a joint meeting with the Thirteenth District Medical Society, in Hotel LaSalle, South Bend, on November fourteenth. Speakers included Dr. Carl P. Huber, of Indianapolis; Dr. William Altemeier, of Cincinnati, Ohio; Dr. Gaza de Takats, of Chicago, Illinois; and Dr. E. J. McCormick, of Toledo, Ohio.

COUNCILOR DISTRICT MEETING

SEVENTH COUNCILOR DISTRICT

The Seventh Councilor District meeting was held on December twelfth, in Indianapolis.

Dr. Cyrus J. Clark, of Indianapolis, was re-elected councilor of the Seventh Councilor District. Dr. Walter L. Portteus, of Franklin, who succeeded Dr. Clark as councilor when Dr. Clark entered military service, resigned, resulting in Dr. Clark's re-election. Dr. Clark will serve until December 31, 1947.

Dr. Leon Gray, of Martinsville, who is also a World War II veteran, was elected president- elect. Dr. O. T. Scamahorn, of Pittsboro, a non-resident member of the local society, succeeded Dr. Charles A. Weller, of Indianapolis, as district president, on January first.

Dr. Horace M. Banks, of Indianapolis was elected secretary-treasurer, succeeding Dr. Norman S. Loomis, also of Indianapolis.

A question hour concluded the meeting, at which physicians in the audience quizzed the "Board of Experts" seated at the speakers' table.

Danville was selected as the site for the 1946 meeting.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. F. M. Gastineau, Indianapolis
President-elect—Mrs. S. J. Petronella, East Chicago
Corresponding Secretary—Mrs. C. L. Bock, Indianapolis
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis
Secretary—Mrs. Leon L. Blum, Terre Haute

The past month each auxiliary member in the United States was sent a letter from our national president, Mrs. David W. Thomas. This letter stressed the need now arising for health education. It urges each member to work for the "particular needs and problems of your community, as they may relate to the state and national auxiliary programs."

There are twenty-six thousand members of our auxiliary, most of whom are in contact with large groups of women in club work. Each of us must be willing to acquaint ourselves with current medical legislative problems and the platform of the American Medical Association concerning the Constructive Program for Medical Care.

DELAWARE-BLACKFORD

Twenty-four members of the Delaware-Blackford Auxiliary met on October twenty-third for the first meeting of the calendar year. Dinner was served at 6:30 P.M. at Shady Oaks. Dr. Gerald Young talked about his experiences in the China-Burma-India war theatre. He displayed a number of articles that he had purchased in that area.

MARION

Approximately eighty members of the Auxiliary to the Indianapolis Medical Society met at the Propylaeum on December fifth for a luncheon. Following a short business meeting bridge was played.

ST. JOSEPH COUNTY

Mrs. P. J. Birmingham entertained the members of the St. Joseph County Auxiliary at her home on November sixteenth. Mr. Vernon T. Root gave a talk on insurance.

VANDERBURG COUNTY

Dr. Herman Combs was the speaker at a dinner meeting of the Woman's Auxiliary to the Vanderburg County Medical Society on November thirteenth.

VIGO COUNTY

A round table discussion on socialized medicine was held at the November meeting of the Vigo County Auxiliary, in Terre Haute. A covered-dish luncheon preceded the program. Mrs. F. M. Gastineau, state president, was present.

HYGEIA MESSAGE

Now that Christmas has passed and we are looking forward to a successful adjustment to a peacetime tempo, let each of us feel that we have a part to fulfill, remembering that we are all working for one great cause; namely, the betterment of health through health education. As the wife, mother, or daughter of a physician you can help by making the public more health-minded, and your silent partner in this endeavor is *Hygeia*, The Health Magazine. *Hygeia* has announced lower rates to physicians and dentists.

Every *Hygeia* chairman and the members of her committee should be sure to read the December issue of *Hygeia*, for it contains an excellent article, "How to Improve Health Teaching," which is of special interest to all educators. Let us all cooperate to make the drive for better health a greater success than ever before.

Mrs. Otto H. Bakemeier,
Chairman of *Hygeia*,
Woman's Auxiliary to Indiana
State Medical Association.

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INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASE CONTROL
Monthly Report—September, 1945

Diseases	*Sept. 1945*	*Aug. 1945*	*July 1945*	*Sept. 1944*	*Sept. 1943*
Chickenpox	34	20	55	35	32
Measles	16	22	39	9	39
Scarlet Fever	87	52	77	100	79
Typhoid Fever	17	5	6	13	10
Paratyphoid Fever	1	0	0	0	0
Whooping Cough	87	135	127	52	171
Diphtheria	31	17	14	35	26
Influenza	12	17	6	14	17
Pneumonia	7	1	0	6	23
Mumps	30	37	58	22	20
Poliomyelitis	77	43	5	108	37
Cerebrospinal Meningitis	13	5	12	5	5
Undulant Fever	6	5	7	2	6
Vincent's Angina	3	0	0	3	0
Tetanus	3	1	0	1	0
Dysentery (Unspecified)	15	0	0	0	0
Amebic Dysentery	1	0	0	0	2
Encephalitis Lethargic	6	4	1	0	0
Noninfectious Encephalitis	1	0	0	0	0
Erysipelas	3	1	1	1	0
Impetigo	2	3	4	0	0
Rabies in Man	1	0	0	1	0
Malaria—acquired outside the United States	8	5	3	5*	1*
Ringworm	3	6	0	0	0
Infectious Jaundice	2	7	2	0	0
Food Poisoning	1	0	0	0	0
Tuberculosis, Pulmonary	177	214	185	216	88
Tuberculosis, Other Forms	6	6	11	9	21

** Not stated as to whether the case was acquired Outside or Inside the United States.*

INDIANA STATE BOARD OF HEALTH
DIVISION OF COMMUNICABLE DISEASE CONTROL
Monthly Report—October, 1945

DISEASES	*Oct. 1945*	*Sept. 1945*	*Aug. 1945*	*Oct. 1944*	*Oct. 1943*
Chickenpox	82	34	20	90	205
Measles	17	16	22	13	186
Scarlet Fever	217	87	52	137	281
Smallpox	1	0	0	2	2
Typhoid Fever	6	17	5	11	12
Whooping Cough	113	87	135	42	109
Diphtheria	55	31	17	40	66
Influenza	26	12	17	9	28
Pneumonia	11	7	1	10	34
Mumps	22	30	37	18	49
Poliomyelitis	36	77	43	37	27
Cerebrospinal Meningitis	8	13	5	12	23
Nonepidemic Meningitis	2	0	1	0	0
Encephalitis, Lethargic	3	6	4	1	2
Malaria, Acquired Outside U.S.	11	8	5	2*	12*
Septic Sore Throat	13	0	8	3	2
Vincent's Angina	1	3	0	0	0
Rubella	5	0	4	0	4
Dysentery	14	15	0	1	0
Undulant Fever	4	6	5	4	8
Conjunctivitis	1	0	0	0	0
Impetigo	1	2	3	4	0
Tetanus	1	3	1	0	0
Infectious Jaundice	1	2	7	0	0
Tuberculosis, Pulmonary	135	177	214	324	326
Tuberculosis, Other Forms	3	6	6	15	43

* Not stated as to whether the case acquired infection outside or inside the United States.

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THROMBOPHLEBITIS, EXPERIENCE AT AN ARMY GENERAL HOSPITAL†

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LIEUTENANT COLONEL S. MARION SALLEY, M.C.**

ROME, GEORGIA

Thrombophlebitis occurs with relative infrequency among soldiers due to their age and healthy vascular systems. However, it is a subject of considerable military importance inasmuch as poor treatment often leads to total disability through enforced limitation in locomotion. During the past few years there have been several new developments in treatment, but there is some difference of opinion as to the relative merits of the methods. In an editorial in *Surgery*, February, 1945, Dr. Frederick A. Coller made certain comments which bear repetition, "A state of indecision always arises when more than one form of therapy in prevention and treatment is available. Medical progress is based on the amassed statistics of groups of individuals vigorously championing one or the other form of treatment. The problem of thromboembolism is at present in this stage. Statistical studies are being compiled in favor of ligation of large veins of the extremities or of the trunk to prevent distant emboli and further progression of thrombosis in these veins. With a similar end in view, enthusiasts for anticoagulant therapy in this same group of patients are presenting a formidable showing in the current literature. There is no doubt that sympathetic block overcomes the vasospasm and thereby aids recovery when such vasoconstriction is present." It is our intention to discuss these therapeutic approaches, to outline the indications for each, and to present certain illustrative cases.

In the preparation of this paper, we are indebted to the Surgical Service for its permission to report many of these cases and for the statistics regarding surgical procedures. A diagnosis of thrombophlebitis has been made in twenty-one cases during the past eighteen months at the Battey General Hospital. Of this number, five developed while here, three postoperatively, one secondary to a battle injury, and one to a fungus infection of the foot. The remaining sixteen developed in other hospitals and were seen here in varying stages of their convalescence. In Table I are reported the statistics regarding surgery at this hospital. The percentage of postoperative thrombophlebitis and pulmonary embolism is gratifyingly low. Barker and his associates[1] reported 0.96 per cent incidence of thrombophlebitis in 172,888 operative procedures, with 0.52 per cent incidence of pulmonary emboli. Culp[2] reporting on 8,163 urological procedures, listed 1.05 per cent incidence of pulmonary embolism. Barker and his associates[3] reported 4.00 per cent incidence of thrombophlebitis following hysterectomy, with 0.70 per cent incidence of pulmonary embolism in the same series. The female abdominal operations

† Presented before the Regional Staff Meeting, Battey General Hospital, May 10, 1945.

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[1] Barker, N. W.; Nygaard, K. K.; Walters, W.; and Priestly, J. T.: *Proc. Staff Meetings*, Mayo Clinic, **15**:769, 1940.

[2] Culp, O. S.: *Bull. Johns Hopkins Hosp.*, **67**:1, 1940.

[3] Barker, N. W.; Cromer, H. E.; Hurn, Margaret; and Waugh, John M.: The Use of Dicumarol in the Prevention of Postoperative Thrombosis and Embolism with Special Reference to Dosage and Safe Administration, *Surgery*, **17**:207, (February) 1945.

TABLE I

INCIDENCE OF POSTOPERATIVE THROMBOPHLEBITIS AND PULMONARY EMBOLISM AT BATTEY GENERAL HOSPITAL

Type of Surgery	Number of Cases	Number of Cases with Thrombophlebitis	Percent	Number of Cases with Pulmonary Embolism	Per Cent
Abdominal (male)	93	1	1.06	0	0.00
Abdominal (female)	39	2	5.1	1(?)	2.5
Hernias	51	0	0.00	0	0.00
Hemorrhoid ligation	54	0	0.00	0	0.00
Miscellaneous	1032	0	0.00	0	0.00
Totals	1269	3	0.23	1(?)	0.07

listed in Table I were all pelvic. The male abdominal operations included colostomies, colostomy closures, appendectomies, gastrectomies, intestinal resections, et cetera. In Table II is shown the relationship between the type of anesthetic agent used and the incidence of thrombophlebitis.

TABLE II

POSTOPERATIVE THROMBOPHLEBITIS AT BATTEY GENERAL HOSPITAL, SHOWING RELATIONSHIP BETWEEN TYPE OF ANESTHETIC AND INCIDENCE OF THROMBOPHLEBITIS

Type of Anesthetic	Number of Cases	Thrombophlebitis Cases	Percent
Ether	2	0	0.00
Caudal	4	0	0.00
Nitrous oxide and oxygen	15	0	0.00
Sodium pentothal	174	0	0.00
Local	214	0	0.00
Spinal	304	1	0.33
Nitrous, oxygen, ether	546	2	0.37
Totals	1255	3	0.28

ETIOLOGY

For this presentation we have undertaken to classify and tabulate the principal well-defined etiologic factors, Table III.

Many doubtful causes have not been included. No effort has been made to elaborate on the ones mentioned. For instance, the increased coagulability occurring in the postoperative state is the result, according to Ochsner[4], of several factors, such as increased viscosity, hypoproteinemia, hyperglobulinemia, increased fibrinogen content, increased antitryptic power, increased peptidase, increased calcium content, and decreased carbon dioxide combining power. It is obvious that an involved discussion of such factors has no place in our program. In order to clarify the subject, the predisposing factors listed in this table have been grouped under five main headings. There can be little argument concerning the importance of blood stasis, infection, trauma, and increased coagulability as causes of intravenous clotting. We believe that you will find it easier to discuss and remember

[4] Ochsner Alton: Intravenous Clotting, *Surgery*, **17**:240, (February) 1945.

TABLE III

PREDISPOSING FACTORS IN THROMBOPHLEBITIS

(A) Stasis of Blood:
Immobilization, postpartum, postoperative, after accidents, or during illness; modified Fowler's position; increased intra-abdominal pressure; shallow respiration; shock; cardio-vascular disease; reflex vasospasm, caused by excessive smoking, injuries, exposure to cold, et cetera; varicose veins; obesity; debility; and advancing age.

(B) Infection:
Local
Infected varicose ulcers; fungus infections; pelvic infections: localized suppurative processes, et cetera.
General
Foci of infection; septicemia; bacteremia.

(C) Trauma:
Local, by damage to vein wall; general, by increasing coagulability of blood.

(D) Increased Coagulability of Blood:
Trauma; postoperative state; anemia; malignant disease; shock; dehydration; blood dyscrasias, such as polycythemia; drugs, such as digital's.

(E) Miscellaneous:
Constitutional diathesis; seasonal variation (higher incidence in winter); geographic distribution (higher incidence in temperate and cold climates than in warm).

the various features of etiology, prophylaxis, and treatment if you consider them under these headings. The part played by blood stasis in intravenous clotting is self-explanatory, and the importance of the various factors listed under this subject in Table III is undisputed. Each of these separate factors has been evaluated in the literature, and each has been proved to have some etiologic importance in retarding the flow of blood. However, stasis alone will not cause intravenous clotting. Some additional factor must be present.

The part played by infection is clearly defined. The importance of foci of infection may be disputed, but the other factors are self-explanatory.

The increased coagulability of the blood secondary to trauma is the subject of much recent work. The effects of local trauma to a vein wall are self-evident, and under this heading one must also include the reflex vasospastic effects of trauma. We are seeing much of that in this war.

Factor D, increased coagulability, is incurring the greatest clinical and experimental interest at the present time. The blood has been shown to clot more easily after operation or after extensive trauma to the body. Malignant disease definitely increases coagulability. In shock and in dehydration the blood often clots quickly. In anemia there is increased clotting because of increase in the blood elements which aid coagulation. As mentioned above, Ochsner has listed many factors which have proved to play a part in postoperative increased clotting. At the present time the subject is still in the experimental stage, although it is being given increasing recognition therapeutically.

The miscellaneous factors listed are presented without comment. Each has been statistically proved, but the exact causes remain unknown.

PATHOLOGICAL ANATOMY

Hunter and his co-workers[5] and McCartney[6] have called attention to some vital features of the pathological anatomy of thrombophlebitis. In the past it has been generally assumed that pulmonary emboli arose from clots in the femoral or pelvic veins. These authors have shown conclusively that the deep veins of the legs are the most frequent sites of thrombosis and the most important source of pulmonary emboli.

In an average autopsy the deep veins of the leg are not examined, but when Hunter and his coworkers extended their autopsies to include this part of the body they found a very high percentage of patients with some deep-vein thrombosis. DeTakats and Fowler[7] have expressed belief that the "iliofemoral segment is never the primary source of thrombosis." The thrombus in the iliofemoral segment is the result of propagation from the following sources: (1) superficial phlebitis of pre-existing varicosities, (2) the veins of the foot, (3) the deep veins of the calf muscles, and (4) the pelvic veins.

SYMPTOMS AND SIGNS

It is not necessary in this paper to discuss the characteristic picture of iliofemoral thrombosis, with inguinal pain, massive edema and cyanosis of the extremity, and fever and leukocytosis. This is a clinical picture familiar to all. However, it must be emphasized that this complete picture is not often seen. Only the foot, or foot and leg, may be involved. Fever may be absent and swelling may be minimal. Tenderness in the calf may be the only sign of venous obstruction. Ochsner and DeBakey[8] have repeatedly emphasized the importance of recognizing quiet venous thrombosis, or as they call it, "phlebothrombosis." Hunter[5] found this type of venous obstruction occurring in over 50 per cent of a group of patients who were immobilized more than forty-eight hours. From a clinical point of view many gradations exist between "pure" thrombophlebitis and "pure" phlebothrombosis (Table IV). For this reason it is usually difficult to classify each individual case according to this nomenclature.

From a clinical point of view it is sufficient to be reminded that venous thrombosis can occur in any patient at bed rest, and that signs of this obstruction may be minimal. It is also important to realize that however minimal these signs, the pulmonary embolism resulting therefrom may be fatal. For this reason we should be constantly on the alert to detect signs of venous obstruction. We should plan our operative and medical therapeutic regimes in such a way that all predisposing factors are eliminated.

TREATMENT OF THROMBOPHLEBITIS—PROPHYLAXIS

In Table V we have listed preventive measures under the same headings which were used in discussing etiology. It is not within the scope of this paper to discuss each of these factors separately, although certain ones should be emphasized. We are all aware of the importance of postoperative exercise, and of the necessity of frequently turning older patients who are confined to bed. This latter policy is followed to prevent pulmonary stasis, but active or passive leg exercises are just as important to prevent similar stasis in the lower extremities. We would like particularly to call attention

TABLE IV

DIFFERENTIATION OF THROMBOPHLEBITIS AND PHLEBOTHROMBOSIS

	Thrombophlebitis	Phlebothrombosis
Pain	Prominent	Absent to moderate
Lymphadenitis	Present	Absent
Homans' Sign	Present	Present
Edema	Prominent	Absent to moderate
Fever	Present	Absent
Leukocytosis	Present	Absent
Sedimentation Rate	Elevated	Normal
Signs of local Inflammation	Present	Absent
Reflex Vasospasm	Present	Absent
Type of Clot	Adherent, "white"	Loose, "red"
Complications	Long-continued edema and disability	Pulmonary embolism
Treatment	Measures to reduce vasospasm Measures to prevent embolization	

TABLE V

TREATMENT OF THROMBOPHLEBITIS—PROPHYLAXIS

(A) To Prevent Stasis of Blood:
Postoperative, postpartum, after accident, and during illness (where feasible): modified Trendelenburg position; leg exercises, active or passive; deep-breathing exercises; frequent changes in position; prevention of abdominal distention; avoidance of tight abdominal binders.
Other measures: preoperative weight reduction; preoperative avoidance of smoking; thorough attention to cardiovascular status, with treatment of any correctable conditions; removal of constricting garments; prevention of exposure to cold, both pre- and post-operative.

(B) Treatment of Infection:
Removal of foci of infection; treatment of all local conditions; use of penicillin and sulfonamides when bloodstream infection is present or probable.

(C) Prevention of Trauma:
Good operative technique.

(D) Decreasing the Coagulability of the Blood:
Correction of anemia; strict attention to fluid and electrolyte balance, and to blood protein levels; correction of blood dyscrasias, such as polycythemia, when possible; prevention of trauma; limited use of drugs, such as digitalis, which increase coagulability.
Anticoagulants: Dicoumarol and Heparin.

[5] Hunter, W. C.; Krygier, J. J.; Kennedy, J. C.; and Sneeden, V. D.: Etiology and Prevention of Thrombosis of the Deep Leg Veins, *Surgery*, **17**:178, (February) 1945.

[6] McCartney, J. S.: Postoperative Pulmonary Embolism. *Surgery* **17**:191, (February) 1945.

[7] deTakats, G.; and Fowler, E. F.: The Problem of Thrombo-embolism, *Surgery* **17**:153, (February) 1945.

[8] Ochsner, A.; and DeBakey, M.: Thrombophlebitis and Phlebothrombosis, *South. Surgeon* **8**:269, 1939.

to deTakats'[9] observations regarding postoperative position. He has found that with the use of the Trendelenburg position more cumbersome methods of exercise are not necessary. He advocates regular deep-breathing exercises, with sufficient postoperative analgesia to encourage free movement. Although, as I have pointed out in a discussion of etiology, the increased coagulability of the blood postoperatively is of importance, we must concern ourselves at this time with measures to prevent stasis of blood. Except in such generalities as correction of anemia, strict attention to fluid and electrolyte balance, prevention of trauma, et cetera, we have insufficient knowledge at the present time to do much about this change in blood-clotting mechanism.

TREATMENT OF THROMBOPHLEBITIS

In Table VI we have listed the aims in therapy and the methods available for achieving these aims. We would like to call particular attention to the fact that choice of therapeutic method has apparently been governed by personal opinion as to the relative importance of the various complications. No one of the available methods will satisfy all of these requirements. Vein ligation is most satisfactory in preventing pulmonary embolism. Anticoagulant therapy will prevent further thrombosis. Sympathetic block reduces fever and edema and relieves pain. It is our intention to present the main features of each form of treatment, with illustrative cases from our series, listing the principal indications for each therapeutic approach.

TABLE VI

TREATMENT OF THROMBOPHLEBITIS

(A) Aims in Therapy:
1. To prevent pulmonary embolism.
2. To reduce edema.
3. To relieve pain.
4. To reduce fever.
5. To prevent extension of the thrombus.
6. To prevent thrombosis in other areas.
7. To shorten convalescence.

(B) Methods Available for Achieving these Aims:
1. Conservative treatment—bed rest, elevation of the extremity, and compression bandages.
2. Measures to relieve vasospasm:
   (a) Paravertebral lumbar sympathetic block.
   (b) Caudal anesthesia.
   (c) Relief of vasospasm by reflex measures.
3. Prevention of pulmonary embolism by vein ligation.
4. Anticoagulant therapy.

If swelling is confined to the foot, or to the foot and lower leg, with little fever, leukocytosis, or pain, conservative treatment may be used. It must be remembered that there exists deficient oxygenation in the involved extremity, with resultant lowered protection against environmental changes. For this reason extremely hot or cold packs should not be used. Residual edema can be minimized by the early use of compression bandages. We wish to emphasize that conservative treatment is applicable only to cases with minimal signs and symptoms. It was used alone in twelve cases in this series.

Correct method of treatment is best shown by the following case: A twenty-seven-year-old soldier had an extensive fungus dermatitis of the right foot. This became secondarily infected and he developed thrombophlebitis, with swelling confined to the foot. There was no fever or leukocytosis. Homans' sign was positive and there was tenderness in the muscles of the calf. Inasmuch as edema did not extend above the ankle it was obvious that the process was confined to the veins of the lower calf and foot. Conservative treatment was instituted, and he made an uneventful recovery with complete subsidence of the edema within ten days.

Incorrect method of treatment is illustrated by the following: A twenty-nine-year-old soldier developed femoral thrombophlebitis with swelling of the left thigh, leg, and foot. His temperature was elevated to 100.0; there was some leukocytosis, and inguinal tenderness was present. He was treated conservatively for two months and then transferred to this hospital. Edema was prominent at the time of transfer and persisted despite the use of compression bandages and paravertebral blocks.

Ochsner and DeBakey[10] have repeatedly called attention to the importance of vasospasm in thrombophlebitis. The inflammatory process in the vein produces this reflex vascular constriction through irritation of the perivenous sympathetics. These nervous pathways may be interrupted by stripping the vein wall or by section and ligation. Some of the symptomatic relief obtained in venous ligation occurs because the sympathetic pathways are interrupted when the vein is divided. This reflex vasospasm is manifested by cyanosis of the extremity, associated with cold skin, excessive sweating, and decreased pulsation of the arteries.

Ochsner and BeBakey showed that paravertebral lumbar sympathetic block would relieve this. They were often able to demonstrate marked relief of signs and symptoms, with rapid subsidence of edema, quick relief of pain, reduction of temperature to normal, and total recovery within a few days. They achieved this by using daily blocks until adequate results had been obtained. We mention this daily use because it is their belief that many of the failures reported have been due to infrequent blocks. It is our own impression, however, that daily use is not always necessary, and that frequency and number of blocks can be decided in each individual case. This is well illustrated by the following: A thirty-two-year-old soldied had a laparotomy on March 3, 1944, for repair of a small ventral hernia and release of intra-

[9] deTakats, G: The Surgical Treatment of Thromboembolism and its Sequelae, *Bull. New York Acad. Med.*, **20**:623, (December) 1944.

[10] Ochsner, A.; and DeBakey, M: Treatment of Thrombophlebitis by Novocain Block of Sympathetics: Technique of Injection, *Surgery*, **5**:491, 1939.

abdominal adhesions. Eleven days later he developed pain and swelling in the left calf and foot, associated with tenderness in the popliteal space and in the calf. A left paravertebral block was done as soon as the signs were definite, and was repeated two days later. All pain was gone within one week and edema had cleared in two weeks.

In some cases it is not possible to institute correct therapy because of military necessity. One soldier, twenty-six years of age, developed swelling in the right foot and leg following a battle injury. Sympathetic blocks were performed three times during his return to the States, each time at a different hospital. Edema was still present nine months after onset.

Paravertebral blocks should be continued until satisfactory results are obtained or until it is obvious that no further improvement can be expected.

A twenty-four-year-old nurse underwent a right oophorectomy on May 2, 1944. Her immediate postoperative course was uneventful, but on the twenty-fourth postoperative day, while on leave, she developed thrombophlebitis in the right leg. She entered a general hospital near her home, and a paravertebral block was done. Her symptoms improved somewhat, and no further blocks were performed. She was returned here about one month later, still complaining of pain and swelling in the foot. Three more blocks were done, with rapid and lasting improvement.

Paravertebral blocks will lessen pain, even if present months after the onset. However, in our experience residual painless edema is not affected. The twenty-six-year-old soldier mentioned above, who had developed thrombophlebitis following an injury, was still complaining of pain in the foot when he arrived here seven months after the onset. This pain was improved by paravertebral blocks, but his edema was unchanged. Blocks were used on four other patients with residual edema without improvement.

Caudal anesthesia has also been used to relieve vasospasm. We do not use it routinely, but it was successfully resorted to in one case in whom paravertebral blocks had been unsuccessful. This thirty-year-old nurse had cervical cauterization and myomectomy on December 5, 1944. On the fourteenth postoperative day she developed swelling involving the entire left thigh, leg, and foot. There was tenderness in the femoral triangle with an enlarged tender gland in the left inguinal region. Her temperature was elevated and there was moderate leukocytosis. Three paravertebral blocks were performed during the following four days.

There was subjective improvement without change in body temperature or in appearance of the involved leg. On the twelfth day four hours of continuous caudal anesthesia was used, and this was repeated on the fourteenth day. Her temperature promptly dropped to normal, and edema was minimal after the sixteenth day. Caudal anesthesia is a relatively simple procedure, requiring less manipulation than paravertebral blocks, and its action can be prolonged. It would appear to be the method of choice in bilateral thrombophlebitis and in many cases of unilateral involvement when paravertebral blocks are unsuccessful.

Vasospasm may also be relieved by reflex means. We have had some success with the use of a heat cradle over the trunk. The feet are allowed to remain at room temperature and are elevated slightly. One ounce of spiritus frumenti may be given at the beginning of each treatment in order to increase peripheral vasodilatation. This treatment may be repeated three or four times daily, with the cradle left in place for an hour. The vasodilatation obtained does not compare with that following caudal anesthesia or paravertebral block, but the method is of value as adjunctive therapy. It may be used in the treatment of indolent ulcers following battle injuries, and in gangrene secondary to trench foot.

In summarizing this phase of the subject it should again be emphasized that reflex vasospasm plays a very important part in the production of signs and symptoms of thrombophlebitis. In our opinion paravertebral block or caudal anesthesia is indicated in every case of thrombophlebitis of more than minimal degree.

These therapeutic procedures should be instituted early, repeated frequently, and continued as long as signs and symptoms persist.

Homans[11] was apparently the first American surgeon who deliberately ligated the femoral vein to prevent embolism. In recent years Allen[12]; Allen, Linton, and Donaldson[13]; Fine and Starr[14]; and Veal and Hussey[15] have reported a large series of cases in which this procedure was successfully done. The opinion of these men is best presented by quoting from the summary and conclusions in the article by Fine and Starr: "The surgical prophylaxis of pulmonary embolism is the procedure of choice among those who prefer a more direct and immediately applicable method for blocking the discharge of an embolus. The risk of ligation of the common femoral, the iliac, and posssibly also the vena cava are minimal and are accompanied by little postoperative disturbance except for transitory increase in edema in occasional instances. This increase in edema is less likely to occur when the common iliac vein is ligated. The selection of the level of ligation is made on the

[11] Homans, J.: Thrombosis of Deep Veins of Lower Leg Causing Pulmonary Embolism, *New England J. Med.*, **211**:993, 1934.

[12] Allen, A. W.: Thrombophlebitis and Pulmonary Embolism, *Kentucky M. J.* **42**:160, (June) 1944.

[13] Allen, A. W.; Linton, R. R.; and Donaldson, G. A.: Trombosis and Embolism: Review of Two Hundred and Two Patients Treated by Femoral Vein Interruption, *Ann. Surg.* **118**:728, (October) 1943.

[14] Fine, J.; and Starr, A.: The Surgical Therapy of Thrombosis of the Deep Veins of the Lower Extremities, *Surgery*. **17**:232, (February) 1945.

[15] Veal, J. R.; and Hussey, H. H.: Surgery of Deep Venous Thrombosis of the Lower Extremity, *Surgery*, **17**:218, (February) 1945.

basis of the evidence of the extent of involvement: (a) the common femoral vein is ligated when thrombophlebitis is limited to the veins below the knee or when pulmonary embolism has occurred in the absence of all signs of involvement; (b) the common iliac is ligated when thrombophlebitis involves the common femoral, external, or common iliac veins, and (c) the vena cava is ligated when there are indications that both common iliacs require ligation. Since the frequency of bilateral involvement is high, bilateral vein ligation is generally indicated."

There can be no doubt that vein ligation is the most effective method of preventing pulmonary embolism. In most patients adequate collateral circulation exists and residual edema is minimal. As previously mentioned, section of the vein divides the nervous pathways involved in the production of reflex vasospasm. For this reason vein ligation is often accompanied by reduction in edema, fever, and pain. For those workers who are particularly enthusiastic about this method, any evidence of venous obstruction, except the most minimal, is indication for section and ligation. In our work it has been reserved for those cases with a history of pulmonary embolism or in whom other methods are unsuccessful in reducing edema, pain, and fever. This policy is illustrated by the following case: This thirty-year-old soldier sustained a perforating wound of the right thigh when struck by shell fragments on June 27, 1944, in Italy. In the course of the original debridement the right femoral artery and vein were ligated. There is no statement in the record as to the exact site of the vein ligation, but subsequent examinations here revealed that it was performed below the profunda. He arrived here in October, 1944. In November an abscess formed in the region of his wound, which was incised and drained. On December 27 the right lower leg began to swell, and on December 29 another abscess in the thigh was opened and drained. At 4:00 A.M. on January 4, 1945, he was awakened by a continuous sharp pain in the right lower axilla, radiating to the upper chest and shoulder. He became dyspneic, and by 8:00 A.M. he was expectorating a bright red, bloody sputum. Vein ligation was not done because of local infection in the femoral area.

The infarcted area cleared uneventfully, but on February 12 he had another pulmonary embolus. On February 13 the right femoral, saphenous, and profunda femoral veins were ligated. His subsequent course was uneventful.

In summarizing ligation therapy it must be admitted that there is constantly-increasing evidence to support the opinions of Homans, Allen, and others. As the pathologic anatomy of this condition is more clearly understood and the surgical techniques better defined, there is no doubt that the method will see increasing use. In the past many cases were regarded as failures because they had pulmonary emboli after ligation. These so-called "failures" were often caused by ligation below the profunda, or by emboli from the other leg. It is now well recognized that ligation should be at the level of the common femoral, or higher. Likewise, the most careful search should be made for bilateral involvement.

Anticoagulant therapy has likewise had its enthusiastic proponents, mainly Barker and his associates at the Mayo Clinic.[3] Heparin is given intravenously, is quick-acting, and is rapidly eliminated from the body. Because of its rapid action it must be given by continuous intravenous drip or by repeated intravenous injections. It acts not by preventing the formation of clotting elements, but by preventing their combination to form a clot. The only effective antidote is whole blood transfusion. Dicumarol acts by reducing the production of prothrombin in the liver. For this reason it acts more slowly than heparin, and its action is more prolonged. It can be given orally in doses of 200 to 300 milligrams daily. The bleeding tendency can be controlled by blood transfusions or the intravenous injection of 64 milligrams of menadione bisulfite.

Barker and his co-workers emphasize the necessity of doing frequent prothrombin tests. Their results were encouraging, and they encountered very little difficulty with bleeding. Without doubt this method is one which requires constant attention and prolonged experience. The main objections are the difficulty of control and the danger of hemorrhage in postoperative patients.

A word should be added here regarding the treatment of pulmonary embolism. Embolectomy has been successfully performed, but it is obviously not to be considered in the ordinary hospital. It has been shown experimentally that many of the ill effects of emboli in the pulmonary circulation are due to reflex vasospasm, especially in the coronary arteries. Changes in the electrocardiogram which were considered typical of acute cor pulmonale have been shown to be due to this vasospasm. Myocardial infarction has occurred during pulmonary embolism. To counter these vasospastic effects, atropine and papaverine are the drugs of choice, and they should be begun as quickly as possible. Papaverine, grains 1 (0.065 grams), and atropine sulfate, grains 1/60th (1 milligram) should be given every four hours for the first two days, and then three times daily for three more days.

CONCLUSIONS

In this review of the etiology, pathologic anatomy, symptomatology, prophylaxis, and treatment of thrombophlebitis and pulmonary embolism it has been obvious that there is considerable disagreement as to the preferable form of therapy.

Early postoperative movement, proper attention to postoperative position, careful management of preoperative and postoperative fluid, electrolyte balance, et cetera, are essential to the successful prophylaxis of this condition. In non-surgical conditions requiring prolonged bed rest the same gen-

eral measures must be carefully carried out. It should be re-emphasized that thrombophlebitis occurs as commonly in medical conditions as in surgical ones. In this series of twenty-one cases only eight followed surgery or injury. After thrombophlebitis has developed, measures to relieve vasospasm are indicated in almost every case. Paravertebral block or caudal anesthesia, used early and frequently, will reduce pain, edema, and fever, shortening convalescence markedly. Socalled "conservative therapy," the term applied to elevation and rest of the involved extremity, is preferable only in cases with minimal involvement. Vein ligation is currently enjoying increasing enthusiasm. It has been clearly shown that the large venous trunks, even including the common iliacs or the vena cava, can be ligated without significant circulatory embarrassment in the lower extremities. The indications and techniques for ligation will become more clearly defined, and there can be no doubt that the method will see increasing use. The status of anticoagulant therapy is not so clear. Heparin and dicumarol will prevent venous thrombosis, but the danger of hemorrhage is considerable, and these agents should be used only by experienced workers under precise laboratory control.

EMPIRICAL TREATMENT OF METASTATIC CARCINOMA

A Case Report

OTIS R. LYNCH, M.D.

MARENGO

This is a report of a case of far-advanced metastatic carcinoma of the thoracic vertebrae, which is clinically much improved twenty-five months after the beginning of empirical treatment.

The patient, a male, aged fifty-two, was first seen April 6, 1943, after he had been treated two months for rheumatism. He had severe pain in his back and legs, and there was so much paralysis of the legs that he walked with crutches and had to be helped into the office. He was referred to a veterans' hospital, and after several weeks he was sent to a second veterans' hospital, one with more complete facilities for studying malignancies. At this second hospital the following diagnoses were established: "carcinoma, metastatic thoracic vertebrae —primary undetermined; compression of spinal cord due to metastatic tumor of dorsal vertebrae." He was given a course of deep x-ray therapy and improved for a few weeks; then he became worse and returned home on August 30, 1943, with a hopeless prognosis.

After he returned home he had terrific pain; a half grain of morphine did not relieve it. Since the beginning of his illness he had lost forty pounds in weight, and there was increasing paralysis of the lower extremities; he was helpless.

The empirical treatment extended over a period of thirty weeks and is described in the three following paragraphs:

1. For seven weeks the patient was given eight tablets of ergotamine tartrate (gynergen .001 gram) daily. Unless they caused nausea two tablets were given every six hours.

2. From the seventh to the twenty-first week (thirteen weeks), the gynergen was continued in the same dosage. Beginning with the eighth week, potassium sulfocyanate was also given in full-tolerance doses. It was given in one and one-half grain sugar-coated tablets, six to twenty-four grains daily.

3. At the beginning of the twenty-first week gynergen was discontinued. The potassium sulfocyanate was continued in full doses; also the patient was given 1/100 to 2/100 grains nitrolycerin every hour for the full ten weeks. The 2/100 grain dose was given unless it caused nausea. At the end of the thirtieth week all medication was discontinued.

At the time of this report, twenty-five months after beginning treatment, the patient has gained forty-five pounds in weight; he has no pain; the paralysis is nearly all gone; and he is learning to walk again.

SUMMARY

An account has been given of a case of far-advanced metastatic carcinoma of the thoracic vetebrae, which is clinically much improved twenty-five months after the beginning of empirical treatment.

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MAXILLOFACIAL INJURIES*

LIEUTENANT COLONEL T. G. BLOCKER, JR., M.C.,
CAPTAIN L. R. WEISS, D.C.
CAMP ATTERBURY, INDIANA

While maxillofacial injuries comprise only a small percentage of all war casualties, they are, nevertheless, of great importance from the standpoint of the patient, who inevitably suffers severe psychic trauma; of the general public, who, wittingly or unwittingly, determine the patient's social and economic future; and finally, of the plastic surgeon, whose greatest skill and ingenuity are challenged by the difficult problems of repair of facial deformities.

During the first World War the occurrence of a large number of face and jaw injuries—approximately 2,500—served as an impetus to the improvement, simplification, and standardization of technique of all types of reconstructive surgery. Since that time rapid advances have been made in the designing and construction of improved types of surgical prosthetic appliances to restore normal facial contour as well as to provide proper dentures for the patient. The value of close co-ordination of dental and surgical procedures in achieving satisfactory results was realized, and this integration of specialties has grown more and more important up to the present time.

The number of maxillofacial injuries in World War II has been estimated as approximately 2 per cent of all casualties entering general hospitals in this country for secondary or definitive surgery.

A large part of these injuries are sustained in combat, although many of them are received as the result of accidental trauma, and as such are comparable to cases seen in civilian practice. Combat wounds are not only more severe than traffic injuries, but they differ in character as well. In the first place, actual explosions may occur within the tissues themselves. The force of missiles, whether bullets, shells, or shrapnel, is also so great that destruction of tissue by avulsion is likely to occur; and secondary damage may be produced to soft tissue, blood vessels, and nerves by extremely small comminuted fragments of bone. For these reasons massive primary and secondary hemorrhages are likely to occur. In addition, war wounds are almost invariably contaminated with tetanus, gas-forming bacilli, and Streptococcus haemolyticus, which greatly increase the danger of complications from infection. The fact that many of these patients survive at all is due to the excellent training of medical first-aid men and the routine use of sulfonamides and plasma at the front lines.

Following primary treatment, overseas' patients are returned to this country for definitive surgery if they require extensive plastic procedure of any kind, and are sent to one of the nine general hospitals which are designated as plastic surgery centers.

About 40 to 50 per cent of the patients show maxillofacial injuries, which in general include wounds, burns, and fractures. The superficial wounds most frequently encountered are caused by multiple, minute, foreign bodies; depressed adherent scars; burn contractures; and distortion of the eyelids, lips, nose, or chin from scarring of the face. Compound injuries vary from loss of soft tissue only and comminuted fractures to involvement of the oral cavity and sinuses, and massive avulsion

Figure I.



(a) Distorted cicotrix, left cheek, resulting from shell fragment wound. *(b) After thorough undermining and closure in layers.*

Figure II.



(a) Deformity resulting from avulsion wound over dorsum of the nose. Left eye was enucleated. *(b) Result following removal hump and shortening of the nose by excision of a "V" of the septal and lower lateral cartilages. A plastic prosthesis is used in the left orbit.*

* Presented before the General Meeting of the Indiana State Medical Association, at French Lick, on November 7, 1945.

Figure III.



(a) Deformity resulting from shell fragment wound with complete obliteration of the labio-alveolar sulcus and loss of alveolar process.

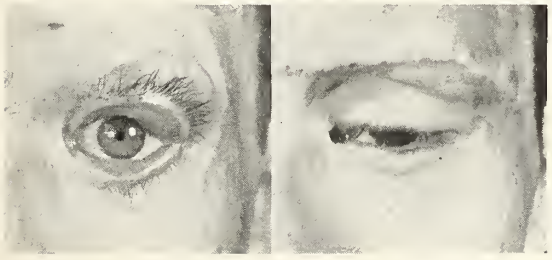
(b) Labio-alveolar sulcus restored with stent graft.

(c) Denture.

wounds of the ear, cheek, orbital region, nose, and upper and lower jaw. Many patients are referred secondarily from neurosurgery and orthopedics for covering of defects produced by large avulsion wounds.

The routine procedure for a patient entering a plastic surgery section begins with a complete and careful study of his condition as a whole, and a detailed analysis of his maxillofacial lesion from the standpoint of distortion, tissue loss, and functional impairment. Impressions are made of the teeth, a preliminary plaster mold is made of the face, as well as routine x-rays and photographs. Temporary dentures are made, if necessary, and

Figure IV.



(a) Ectropion resulting from severe burn of upper and lower lid.

(b) Ectropion corrected by full-thickness skin graft from the post-aural areas.

flexible acrylic extra-oral prostheses are fitted where required to conceal the more deforming types of injuries, such as massive avulsion wounds of the cheek and complete or partial loss of the lower jaw. A morale furlough is given each patient whose condition permit, and following his return he is prepared for operation.

In many cases patients with massive injuries of the lower face have lost thirty or forty pounds of weight, and these are placed on high-caloric diets with supplementary vitamins. Hematocrit and nitrogen studies are made where indicated, and transfusions are given if advisable. Medical diseases, such as malaria and dysentery, are treated, and orthopedic and neurosurgical consultations are held if the patient has associated injuries which require later treatment on another service. Likewise, patients with infections of the sinuses and naso-respiratory passages are treated by nose and throat specialists until their condition permits reconstructive procedures. Meanwhile, the plastic surgeon, together with his dental consultant, has made for the patient a detailed plan of operation after careful consideration of all factors involved. The formulation begins with a clear definition of end-results to be achieved in terms of function and appearance. Massive wounds of the lower face are generally accompanied by marked disturbances of speech, as well as impairment of mastication and swallowing. To achieve good cosmetic results the importance of symmetry and normal facial contour and profile are to be considered first of all. Scar contractures must be relieved, and scarring itself must be reduced to a minimum. Grafts and flaps must approximate as nearly as possible the normal texture, thickness, and color of the face. Proper proportion of the upper and lower lips, and a smooth, non-interrupted muco-cutaneous border are other points to be kept in mind. The ultimate aim of reconstructive surgery, of course, is the restoration of the patient to his normal appearance. Failing to accomplish this, we at least hope to enable him to walk on the street with his deformities unnoticed by the casual observer. Because of our human limitations we fall so short at times that we are almost tempted to release the patient

Figure V.



(a) Deformity produced by shell-fragment wound resulting in marked depression and scarring in the right cheek.

(b) Restoration following excision of cicatrix and improvement of contour by derma-fat graft.

without operative procedure, giving him a perfectly disguised nose, ear, or cheek of latex or flexible acrylic. Since we are dealing almost exclusively with young individuals, however, we feel that we are justified, in almost every case, in making an effort at plastic repair, and the patients invariably insist upon it.

Decision as to operative technique depend by and large upon the amount and kind of tissue lost and the availability of material for reconstruction. There are three general techniques of plastic repair. The first of these, rearrangement of existing tissues, includes all operative procedures in which transplants are not required. The simplest procedure is excision of the scar, undermining of the surrounding tissue, and careful approximation of the layers, using staggered suture lines if necessary to follow the normal lines of the face. This is applicable to wide, depressed, and adherent scars where the tissue loss is not severe. For the relief of tension or where contractures have occurred from burns or scars, Z-plasties, advancement, or rotational flaps are employed. Wide surface defects of the malar region and forehead not close to the commissures of the eye or mouth may be remedied by the process of multiple excision. Here portions of the scar are excised in stages with ample time between operations for subsidence of reaction and relaxation of the skin. Because of the enormous elasticity of the face, a scar may thus be pulled bit by bit to a final position inside the hairline, where it becomes unnoticeable. Whenever the deformity may be relieved without the use of flaps or grafts the cosmetic results are better since transplanted tissue never resembles its surroundings perfectly in texture and pigmentation.

Large surface defects of the face must be covered by grafts or flaps to secure sufficiently large amounts of tissue. Thick split grafts, which are so valuable on unexposed areas of the body because of the simple technique and ease of take, have only limited usefulness on the external face since they undergo considerable contraction and frequently present a wrinkled appearance. Their chief use is in connection with stent-grafting and for covering of burned areas. They also serve as temporary dressings to allow for tissue reaction to subside until more satisfactory procedures can be attempted.

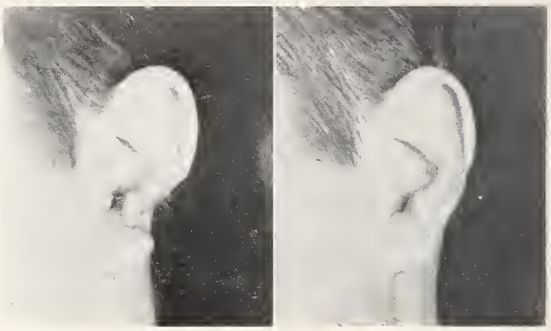
Figure VI.



(a) Deformity of nasal bridge resulting from shell-fragment. wound.

(b) Restoration by excision of "V's" from nasal septum and lower lateral cartilages to get adequate skin and elevation of the nasal bridge by preserved cartilage graft.

Figure VII.



(a) Deformity of the ear from bullet wound.

(b) Result following transfer of flap from the post-aural area.

Stent grafts, also known as epithelial inlay or outlay grafts, are employed chiefly to replace mucosa of the mouth, nose, and conjunctival sac, and are composed of thick-split grafts wrapped around an impression made of dental compound of the cavity to be lined or the irregular surface to be covered. They are used in the mouth to relieve obliteration of the labio-alveolar and buccal sulci in order that artificial dentures may be worn, and to produce an epithelial-lined cavity for the support of a permanent intra-oral prosthetic appliance where the loss of a portion of the maxilla produces marked facial deformity. The chief indications for stent-grafting in the nose are atresia of the nostril and loss of the bony frame-work, in which case normal contour is maintained by a prosthesis attached to the teeth or to the upper denture.

Following enucleation of an eye the stent graft is employed to line the orbital cul-de-sac where such marked contraction has occurred that an artificial eye cannot be accommodated. Other common uses are in reconstructive work about the eyelids and ear and for lining pedicle flaps which are to be used to replace the entire thickness of the cheek—in short, stent-grafts are employed wherever proper pressure and immobilization of a graft cannot be obtained by the ordinary mechanical means.

Full-thickness grafts are employed to cover areas in which there has been loss of skin and a smooth, supple, elastic surface is required. For large defects grafts are usually taken from the abdomen. Small grafts are taken either from the post-aural space or from the "V" of smooth skin between the beard and the hairline. Occasionally grafts are taken from the scalp for the reconstruction of eyebrows. Full-thickness grafts offer the greatest risk of all transplants so far as successful take is con-

Figure VIII.



(a) Deformity produced by avulsion wound, marked scarring over the dorsum, and loss of anterior half of left ala.

(b) Coverage of defect by collar tube.

(c) Appearance on discharge from the Army.

cerned, calling for careful preparation of the recipient area, delicate operative technique, definite requirements of pressure, and absolute immobilization.

Grafts of derma and fat are occasionally used to restore contour where no additional supportive structure is necessary. Fascia is of value chiefly for the relief of small depressions, for maintenance of the contour of the face in facial palsy, and for relief of ptosis of the eyelids.

Cartilage is employed for defects of the forehead and bony prominences; for elevation of the eye following dropping of the whole malar bone; and for use in reconstruction of the nose and ear. Preserved cartilage has been found to be a satisfactory agent for this purpose.

Bone grafts are generally taken from the ilium or rib. They are employed chiefly for bone loss in the mandible and occasionally in the maxilla. Although small amounts of bone loss around the angles of the jaw can be compensated for as a rule by the shifting of the angle of the jaw forward, in the body of the mandible and the symphysis even minimal loss of bone produces severe malocclusion. Bone grafts in every case must be preceded by a long period of preparation of at least three to six months until all reaction has subsided and sequestra have been extruded. During this time fragments are maintained in as normal position as possible by the use of cast-metal splints.

The third method of plastic repair is the use of delayed and pedicle flaps. They contain skin and subcutaneous tissue, and are required to replace loss of the full thickness of the cheek, lips, or chin. They are also usually employed for major rhinoplastic procedures. For small defects collar pedicles are made in the supraclavicular region where the skin is soft and pliable and most nearly matches the color and texture of the face. For larger areas, chest, thoraco-epigastric, and abdominal flaps are employed, and it is often necessary to transfer tubes to the face by the use of the arm as a carrier. Where lining tissue is lost, as in the case of massive avulsion wounds of the cheek, the inner surface of the flap is covered with a thick-split graft or doubled on itself. For construction of the chin a double flap is made in order that a bone graft may later be supported.

Since transplants to the face are likely to be conspicuous because of their color, Brown and Byars have advocated the introduction of pigment by color implantation to provide better blending with the adjacent tissues. These are most successful where there is a dead-white or yellowish appearance of the flap or graft and for smoothing out the vermilion border.

In conclusion, I should like to point out that our obligation to the patient includes something which to him is even more important than the repair of the most disfiguring of facial deformities. This is the maintenance of morale. The first consideration should be to have the patient completely worked up within the first few days of admission. Secondly, he should be advised in conference as to his ultimate prospects from a functional and cosmetic standpoint, and told the length of time necessary for the various procedures and the reasons for delaying operation until he is in the best possible physical condition. Next, the patient should be seen frequently on rounds. A fourth consideration is the use of temporary prosthetic appliances.

Finally, every effort should be made to secure furloughs for the patient between stages of operation when travel is feasible. Not only do furloughs serve an immediate purpose in raising the patient's morale, but they provide an opportunity for him to combat his depression, anxiety, and feeling of inferiority, and is a means of gradual adjustment to life among normal individuals in a normal environment.

(The illustrations used in connection with this article are United States Army photos.)

MODERN PSYCHIATRIC TREATMENT*

GRANT E. METCALFE, M.D.
SOUTH BEND

Strictly speaking, all medical men, general practitioners, and specialists alike practice a form of psychiatry. An example of this may be what is loosely called "bedside manner," which is supposed to convey to the patient the element of assurance. Usually other aspects of psychotherapy are also a necessity. We have to "discuss" the situation with the patient and "persuade" him to take the proper course. Prior to this we have partially provided some "catharsis" if our history-taking has been adequate and the patient has been permitted to tell his story in his own way.

If for no other reason than making better physicians of ourselves, we should be interested in the psychiatric aspects of patients; otherwise we are satisfied with half-truths and are often extremely unscientific in stopping short of an attempt to determine the real cause of the symptoms. Even though the patient is suffering from a pneumonia there is an emotional and therefore a psychiatric aspect to his illness that cannot always be best handled by the appropriate sulfonamide or penicillin alone. This takes us into the important field of psychosomatic medicine. In practice as old as the art of medicine it is new as a scientific discipline. At the Mayo Clinic 44 per cent of five hundred consecutive patients were reported by Moersch[1] to have psychogenic factors of varying degrees. Ebaugh[2] on questioning professors of medicine in his survey of psychiatric education in sixty medical schools in this country, concerning the frequency of psychiatric problems, found their answers to give an average of about 35 per cent. Strecker[3] stated, "It is not an overstatement to say that fully 50 per cent of the problems of the acute stages of an illness and 75 per cent of the difficulties of convalescence have their primary origin not in the body, but in the mind of the patient."

Assistant Surgeon General Treadway[4] said, "Four in every ten persons applying for medical advice in public dispensaries are invalided because of mental illness of this type."

Dunbar, Wolfe, and Rioch[5] point out that these figures are based on clinical impressions rather than careful determinations, and that general physicians and even psychiatrists made aware of psychic factors in their enthusiasm sometimes overlook the fact that traumatic events or situations which endanger health occur in the lives of every human being as part of the eternal struggle between individual and environment, and that their mere discovery in the past life of the patient, or immediately preceding the onset of an illness, is no indication of psychogenesis or even of need for psychiatric intervention. "It is the patient's ability to adjust to such situations, especially his pattern of reacting to them, the degree of pent-up anxiety, the nature and seriousness of his conflicts, that must be evaluated."

These workers, on the basis of a routine survey of groups of hospital admissions over a two-year period, conclude:

First: "The emotional factor played an important role in the illness in more than a third (38.94 per cent) of the total admissions, and probably in a much greater proportion in view of the many patients excluded from adequate investigation because the illness at the time of admission was too far advanced, or the situation otherwise too unfavorable, to permit the establishing of this fact."

Second: "The emotional factor played a role in more than three-quarters (78.67 per cent) of all patients found suitable for psychiatric investigation."

Third: "The emotional factor was of therapeutic significance in more than two-thirds (68.22 per cent) of the patients of whom an adequate examination could be made."

Thus, it appears that they are in general accord with the clinical impressions of others, and it is interesting to note that 95 per cent of their group showed definite organic damage. These authors also feel that in a routine study of total admission groups it is relatively easy to find patients in whom a brief psychiatric contact may profoundly alter the course of the illness.

Halliday[6, 7] found evidence of a marked increase "in chronic and recurring neurotic illnesses as well as in many examples of organic illness labeled by such terms as anemia, rheumatism, gastritis, peptic ulcer, bronchitis, et cetera (psychosomatic illnesses)." Already more than half of our patient hospital days are devoted to the care of the chronically ill. Patients such as these require one-half the annual services of physicians and almost three-fourths of the annual bedside nursing days, according to Perrott and Holland.[8] Recently Perrott[9] estimated that more than fifteen thousand ad-

* Read before LaPorte County Medical Society, in October, 1945.

[1] Moersch, Frederick P.: Psychiatry in Medicine, *Am. J. Psychiat.*, **11**:831-843, 1932.

[2] Ebaugh, Franklin G.: The Crisis in Psychiatric Education, *J.A.M.A.*, **99**:703-707, 1932.

[3] Strecker, Edward A.: Mental Hygiene, Nelson Loose-Leaf Medicine, Vol. VII, Chapter XII.

[4] Treadway, Walter L.: The Place of Mental Hygiene in a Federal Health Program, *Reprint No. 1731 from the Public Health Reports*, **51**:8-181, 1936.

[5] Dunbar, H. Flanders; Wolfe, Theodore, P., and Rioch, Janet McK.: Psychiatric Aspects of Medical Problems, *Am. J. Psychiat.*, **93**: 649, 1936.

[6] Halliday, J. L.: Social Pathology, *Brit. M. J.*, **2**:1012, 1938.

[7] Halliday, James L.: The Incidence of Psychosomatic Affections in Britain, *Psychosom. Med.*, **7**:135, 1945.

[8] Perrott, G. S., and Holland, D. F.: Chronic Disease and Gross Impairments in a Northern Industrial Community, *J.A.M.A.*, **108**:1876, 1937.

[9] Perrott, G. S.: The Problem of Chronic Disease, *Psychosom. Med.*, **7**:21, 1945.

ditional physicians and forty thousand hospital beds will be required to maintain present levels of service to chronically ill in an increasing and aging population.

Rowntree[10] states that as of February 1, 1944, some thirteen to fourteen million selectees had been examined, and approximately four to five million rejectees or men discharged from service. More than one-third of the rejectees and more than 40 per cent of the dischargees were due to neuropsychiatric reasons. These figures are exclusive of psychosomatic diseases. About one-seventh of them were suffering from purely neurological disorders, and three-sevenths from mental deficiency. Of the three-sevenths having a mental illness there is no breakdown as to the number who were psychotic or psychoneurotic.

Rennie[11] notes that of the first two hundred seen at the New York Rehabilitation Clinic, 54 per cent of the dischargees were psychoneurotic.

Pavlov first irrefutably demonstrated the truth of "no psychosis without neurosis," for all with temporary or permanent "neurotic" manifestations do not become mentally ill, but all mentally ill patients do have "neurotic" manifestations. The early ones are much easier to treat. This is of importance to us because the problem of mental illness represents the largest single medical problem of today. More than half the hospital beds of this country are occupied by this type of patient. This represents an enormous financial burden to the taxpayers. Because these patients are often not treated early, they become chronically ill and most often spend the greater part of the remainder of their life in an institution. Pollock[12] estimates that the economic loss to the United States in 1937, due to mental illness, amounted to approximately one billion dollars.

Other psychiatric disorders of concern to the community and the profession are the problems of delinquency, chronic alcoholism, drug addiction, epilepsy, and criminality. In some of these the mental hygiene approach is of value. Your author[13] has pointed out the value of the Alcoholics Anonymous movement in the handling of alcoholics and referred to other methods of treatment, such as the conditioned reflex treatment. The value of the use of anticonvulsant medication, such as bromides, phenobarbital, and phenyl hydantoin singly or in combination in epilepsy is well known. More recently 3,5,5, trimethyloxazolidine-2,4, dione (tridione) and perhaps glutamic acid[14] have been valuable in petit mal type of seizures. Ten of your author's cases with petit mal type electroencephalograms receiving tridione appear to be responding better than with other type of medication.

The problem of treatment of the neuroses (including psychosomatic disorders) and the psychoses is best understood if we realize that a psychoneurosis is a compromise with the emotional demands of reality. It enables the individual to hang on to reality and yet to regress and satisfy immature inclinations. When reality has been abandoned, then he is psychotic.

Rest[15] and vacation are the first things a physician thinks of in dealing with illness of emotional origin. Probably he recognizes that symptoms are due to external pressure of work or family life which induce emotional conflicts. He thinks first of reducing the pressure. It is felt, and rightly so, that in many instances rest will have a salutary effect. To be given permission by an authority, such as a physician, to give up one's duties and go to bed does much to reduce and remove symptoms. At about the turn of the century, S. Weir Mitchell achieved fame by prescribing the "rest cure." It worked very successfully because it catered to some of the most basic needs of individuals, particularly psychoneurotics. The patient was removed from the struggle of life and was nursed, massaged, pampered, and well fed. In short, he was treated as an infant, and all the infantile longings called forth were satisfied. Symptoms do disappear, and in many instances improvement is noted for some time. In many patients frequent repetition of this rest cure is necessary. Unfortunately, a great number of patients become invalids for life, with little improvement of their character by treatment providing so much secondary gain. Rest has its value in improving symptoms, but does nothing to make the patient understand himself. This is particularly true when the matter of hypochromic anemia, decreased blood pressure, and/or metabolic rate, autointoxication, focal infection, endocrine dysfunction, avitaminosis, and adrenal cortical insufficiency are thought to be the cause of his difficulty, and the patient is warned to "take it easy." Rest does not show him what has made him ill nor does it cure his emotional conflicts. Rest cures and the "take it easy" advice actually are harmful to many people, particularly to the psychoneurotics, a great many of whom not only have to be told but pushed to carry on in spite of their symptoms. This decision should be dependent upon complete personality studies if one will avoid the responsibility of making chronic invalids out of many people.

It is your author's[16] opinion that few outside of

[10] Rowntree, Leonard G.: Psychosomatic Disorders as Revealed by Thirteen Million Examinations of Selective Service Registrants, *Psychosom. Med.*, **7**:27, 1945.

[11] Rennie, T. A. C.: Psychiatric Rehabilitation Therapy, *Am. J. Psychiat.*, **101**:476, 1945.

[12] Pollock, Horatio M.: Economic Loss Due to Mental Disease in New York State and the United States, 1937, *Reprint No. 9 from The American Association for the Advancement of Science*, p. 156, 1938.

[13] Metcalfe, Grant E.: Alcoholics Anonymous, *J. Indiana M. A.*, **37**:684, 1944.

[14] Price, J. C.; Waelsch, H.; and Putnam, T. J.: dl-Glutamic Acid Hydrochloride in the Treatment of Petit Mal and Psychomotor Seizures, *J.A.M.A.*, **122**:1153, 1943.

[15] Weiss, E., and English, O. S.: *Psychosomatic Medicine*, W. B. Saunders Co., Philadelphia, 1943.

[16] Metcalfe, Grant E.: Chronic Fatigue, *J. Indiana M. A.*, **37**:70, 1944.

the psychiatric field recognize that the unconscious urge to regress from the responsibilities of an adult life are in constant operation. We see this normally in the successful business man who purchases the farm on which he was raised (or symbolically another one) and does the things he day-dreamed of as a child. Actually, during his week ends or vacation periods he regresses to the happiest period of his life—his childhood—when he was cared for by his parents and was relatively free of responsibilities. There are many other so-called "normal regressions." Sleep is probably to a degree regressive. Physical illness furnishes many opportunities to regress from one's responsibilities as an adult. When continued rest as a result of physical illness is encouraged, the physician helps the individual to develop and further fix regressive phenomena, thus increasing the possibility of delayed recovery, chronic invalidism, and chronic fatigue.

In the newborn all of his energy is tied up in getting a full stomach. Later some of it is diluted from this oral activity as bowel and bladder habits are established. This is still further diluted as the child comes in contact with other children, teachers, and so forth. Eventually, if progress has been satisfactory, because he is biologically mature he externalizes much of his energy in contact with everyday work activities, recreation, the church, and the opposite sex. He is then a mature adult and very little energy beyond that necessary for good function is left within himself. If externalization of energy is adequate, there is no excess left within him to overload his points of emotional conflict and to shuttle back and forth within him, and thus cause fatigue as it endeavors to express itself.

Balancing of activities is an absolute necessity if we are to properly externalize an adequate amount of energy to cut down on fatigue, chronic invalidism, neuroses, and psychoses brought about by accentuating the rest cure and minor physical manifestations.

If the above principals are remembered and utilized, we will be able to handle a large percentage of psychoneuroses in their early stages. A recent paper by Brodman,[17] et al., notes that the failure to recognize personality factors in disease results in needless and extensive investigation and hospitalization; puts a strain on such facilities and the physicians; and also serves to intensify and fix a neurosis. A long convalescence increases anxiety and diminishes self-confidence. When the personality disturbances are recognized, early psychotherapy may be successfully administered by any physician.

In an experiment conducted by Powers,[18] 136 patients in an experimental group, as compared with a control group of 98, he found that patients who had major abdominal surgery and were allowed to become ambulatory one to three days after surgery returned to work in approximately one-half the time required by those patients who were kept in bed the usual number of days after surgery. In the two groups postoperative complications were the same, and minimal. The convalescent period was reduced by approximately one-half.

In a group of 645 patients suffering from atypical pneumonia, Rusk[19] demonstrated that an organized physical reconditioning and educational program shortened convalescence from an average of forty-five days, with 30 per cent recurrences, to thirty-one days, with 3 per cent recurrences. Karpovitch[20] has made a more recent study of patients with atypical pneumonia on a more accelerated program. The patients were able to leave the hospital in about one week less than the twenty-three days of the average hospital stay if and when they were allowed to engage in "stepping-up exercises" within forty-eight hours of becoming afebrile instead of after six days or more. Probably a major factor in this time-saving is the difference in the attitude produced in the patient by an awareness that his physician looks on him as being well enough to be out of bed and exercising.

Experience gained from patients[21] with head injury indicates that a great number of the symptoms of the post-traumatic syndrome are related to the anxiety engendered during prolonged bed rest. To urge the patient to get out of bed as soon as possible, or when he desires, has become common practice, the inference being "that not the least important point of the treatment is that the seriousness of the injury is minimized not only by the statements of the physician, but by permission for early activity."

No direct advice incompatible with the patient's religious and parental training should be given. We can assist the patient to overcome his resistance to treatment. Terrorizing the patient is both barbaric and inhuman, and does not assist a patient in understanding the nature of his difficulties, and thus recurrence can be expected. Placebos are of value until the physician runs out of placebos, and then the patient runs out on him. The rest and vacation cure fails to show the patient what made him ill, and does not cure his emotional conflicts. If more intensive therapy should be required, the patient should be referred to a psychiatrist. Successful application of psychotherapeutic principles in all illnesses will avoid the loss of many of our patients to the cultists.

[17] Brodman, Keeve: Psychology of Convalescence, *J.A.M.A.*, **129**:179, 1945.

[18] Powers, J. H.: Early Activity of Postoperative Patients, Convalescence and Rehabilitation, *Report No. 2, National Research Council*, April 15, 1944.

[19] Rusk, H. A.: Report on Convalescent Training in Army Air Forces Hospitals: A Summary of the First Fifteen Months' Experience, *Report of Baruch Committee on Physical Medicine*, p. 90, April, 1944.

[20] Karpovitch, Peter: *V. Communication to the Committee on Convalescence and Rehabilitation*, National Research Council, 1944.

[21](a) Spurling, R. G., in discussion on McKenzie, K. G.: One Aspect of the Post-traumatic Syndrome in Craniocerebral Injuries, *Tr. Am. Neurol. A.* **69**:103, 1943.

(b) Shearburn, E. W., and Mulford, E. H.: Ambulatory Treatment of Cerebral Concussion, *Bull. U. S. Army M. Dept.*, No. 69, p. 36, 1943.

In dealing with the psychoses we must recognize that certain patients, such as arteriosclerotics and seniles, have an unfavorable prognosis, but many can still be cared for in the community. Others must be sent to a psychiatric hospital in order to protect themselves and the community, or because the cost of continued psychiatric care would be prohibitive.

Many patients with central nervous system syphilis will be hypochondriacal, and they serve to emphasize the necessity for adequate physical examination and indicated laboratory procedures. Fever therapy, polyvalent arsenicals and possibly penicillin appear to be of value if treatment is instituted early. Electric shock therapy as an adjunct may be of value in controlling the immediate symptoms.

Other psychotic patients may be treated with one of the various forms of shock therapy. Depressive, and to a lesser degree manic, patients appear to give the best response.[22, 23] More recent schizophrenics may also respond, but usually it is of little value to attempt to treat a schizophrenic of long duration. Exceptions are encountered. Convulsive therapy with metrazol or electricity are the most widely used forms of shock therapy. There is an inclination to believe that with paranoid coloring the response is better to metrazol than to electricity. Substandard risks, those with osteoporosis, recent surgery, fractures, et cetera, can often be treated if the use of curare precedes the treatment. In the schizophrenic, insulin shock appears to have a larger percentage of favorable responses.

The governor's commission[24] in New York State has suggested that all state hospital patients have an opportunity to be treated with shock therapy, noting a definite decline in patient days in those state hospitals where it is extensively used.

Insulin[25, 26] is also of value in sub-coma doses in many patients, and can often be carried out on an ambulatory basis. Doussinet,[27] et al., reports the use of small doses of insulin in combination with infinitesimal doses of colloidal gold solution in an ambulatory treatment of schizophrenics, chiefly of the catatonic variety. Rennie[28] has pointed out that insulin frequently assists in controlling tension and acts as a sedative.

With insulin psychotherapy may be administered right along with the treatment. When the convulsive agents are utilized there usually is too much memory disturbance to permit any but superficial psychotherapy while treatments are being administered closely. After the treatment has been terminated is the best time for psychotherapy. It is believed that from all the research the shock therapies have stimulated there will eventually come methods of producing the same changes in the organism, and a psychiatric recovery.

Evidence has shown that prefrontal leukotomy[29, 30] is of value in some cases of intractable schizophrenia. Patients mildly ill may be treated conservatively if the circumstances warrant it, keeping in mind that depressives and many schizophrenics not only may but sometimes do commit suicide.

The physician's duty often lies with the situation and not exclusively with the patient. In this connection the familiar sedatives, such as bromides, chloral hydrate, paraldehyde, and the barbiturates, may be referred to. Narcotherapy with or without psychotherapy has gained many advocates. Sulfonal and trional (0.6-0.75 gms.), because they are slowly absorbed and act late, may have special indications.

There is reason to believe that as the indication and procedure for administration become more precisely elaborated, the use of the estrogen treatment in involutional melancholia will be more valuable.

Moore[31] has pioneered the use of suprarenal cortical extract in the depressive reactions and chorionic gonadotropin in the schizophrenics.

Thiouracil has renewed the psychiatrist's interest in the thyroid gland. Your author in using it in forty-five cases has found it of value in certain anxiety states and some hypertensives, preferably with an increased metabolic rate. At least it appears to render some unnecessary surgery of the thyroid less imperative than formerly.

Avitaminosis should be treated in much the same manner as any other underlying illness, such as pneumonia or diabetes would be treated.

A few patients require treatment for an underlying disorder of carbohydrate metabolism or a pernicious anemia.

Medical as well as general social consideration continue to narrow the gap between psychiatry and medicine.

The day draws closer when every physician will not feel that an illness must be "either" psychogenic "or" somatic. The thought must prevail that we are dealing with a living event in a living organism in which both psychic and somatic factors play a part.

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[22] Metcalfe, Grant E.: Electrical Convulsion Therapy in Mental Disorder, *J. Indiana M. A.*, **34**:455, 1941.

[23] Bennett, A. E.: An Evaluation of the "Shock" Therapies, *Psychiatric Quart.*, **19**:465, 1945.

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[30] Kisker, G. W.: Abstract and Categorical Behavior Following Therapeutic Brain Surgery, *Psychosomat. Med.*, **6**:146, 1944.

[31] Moore, T. V.: Physiological Factors in the Treatment of Mental Disorders, *Psychiat. Quart.*, **16**:765, 1942.

INFLUENZA VIRUS VACCINE, TYPES A AND B, FOR GENERAL USE

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Twelve years have elapsed since Smith, Andrewes, and Laidlaw[1] described the isolation of epidemic influenza virus from patients ill with the disease. These authors utilized suitable intranasal inoculation of ferrets with oral washings from cases, and in successful experiments observed characteristic thermal responses, involvement of the upper respiratory tract, and pulmonary consolidation as caused by the virus.

Following this classical publication, voluminous literature on the filterable virus aspect of influenza has grown up. British, American, Russian, and Australian investigators have contributed to this important study. It is not our purpose here to review this subject, since this has been done so admirably by Francis[2] (in a review of sixty-six publications) in this country, and Stuart-Harris[3] (in a review of one hundred seven publications) in England.

During the past twelve years much work has been directed toward securing artificial immunity against epidemic influenza. This problem appeared at first to be simpler than has been found to be the case. Without going into numerous difficulties encountered in influenza immunization, it may be mentioned that most researches on this question have been directed either at preparation of a suitable virus vaccine for hypodermic injection well in advance of expected influenza, or preparation of high-potency anti-serum for prospective eleventh-hour passive protective use by oral spray a few days in advance of and during appearance of a major wave of influenza.

We have worked on the laboratory aspects of both of the above procedures, and are indebted to Thomas Francis, Jr., M.D., for many suggestions about influenza virus vaccine, and to Frank L. Horsfall, Jr., M.D., for suggestions and help in preparation of antiserum. The status of this work in our laboratory about a year ago was indicated in two reports.[4, 5] During this interim the war has ended, and prospective influenzal immunizing agents, if proved effective, henceforth will be used chiefly in civilian cases.

In light of our previous work made necessary as a military exigency, it is the purpose of this report to describe influenza virus vaccine, types A and B, which may now be prepared on a large scale for general use on basis of the efficacy this vaccine has exhibited in the prevention of naturally-occurring influenza[6] and in the prevention of experimentally-induced influenza.[7, 8] We have used the specified PR 8 and Weiss type-A viruses, and Lee type-B virus for production of vaccine for both military and general use.

REFINED AND CONCENTRATED INFLUENZA VIRUS VACCINE

We have prepared for military use during the war about five and one-half million doses of influenza virus vaccine, types A and B. This vaccine has been prepared by established methods of inoculating embryonated eggs (in the ten-day incubated stage) with optimum doses of the above strains of influenza virus. Such inoculated eggs are incubated two additional days, whereupon the periembryonic fluids of the eggs (at that time having very high virus titers) are collected aseptically. These virus-containing fluids are processed, as indicated below, in order to free the virus from various impurities and then concentrate it into one-tenth volume. Concentrates from the different strains are then blended properly and inactivated with formaldehyde. Exact methods and technique have been established by the National Institute of Health following the work of Thomas Francis, Jr., M.D., and the Commission on Influenza of the Board for Investigation of Epidemic Diseases of the United States Army. Satisfactory vaccine in two weekly doses of 0.1 cc. each immunizes Swiss mice against 10,000 LD 50 of active type-A mouse lung virus, and in two weekly doses of 0.001 cc. each immunizes against 1,000 LD 50 of active type-B mouse lung virus. The lower degree of virulence of type-B virus makes challenge doses of this type greater than 1,000 LD 50 impracticable, and mice

* From Lilly Research Laboratories, Indianapolis, Indiana.

[1] Smith, W.; Andrewes, C. H.; and Laidlaw, P. P.: A Virus Obtained from Influenza Patients, *Lancet*, **2**:66-68, 1933.

[2] Francis, T., Jr.: Influenza: Methods of Study and Control, *Bull. of the New York Academy of Medicine*, pp. 337-355, (July) 1945.

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[4] Powell, H. M.: On the Preparation of Purified Influenza Virus Vaccine, *Proc. Ind. Acad. of Science*, **54**:66-74, 1945.

[5] Powell, H. M.: Rabbit Antiserum Against Influenza A and B Viruses for Inhalation Prophylaxis Against Epidemic Influenza, *J. Indiana M. A.*, **37**:18-20, 1944.

[6] Commission on Influenza: T. Francis, Jr., Chairman: A Clinical Evaluation of Vaccination Against Influenza; Preliminary Report by Members of the Commission, *J. A. M. A.*, **124**:982-985, 1944.

[7] Francis, T., Jr.; Salk, J. E.; Pearson, H. E.; and Brown, P. N.: Protective Effect of Vaccination Against Induced Influenza A, *Jour. Clin. Investigation*, 1945, **24**: 536-546.

[8] Salk, J. E.; Pearson, H. E.; Brown, P. N.; and Francis, T., Jr.: Protective Effect of Vaccination Against Induced Influenza B, *J. Clin. Investigation*, **24**:547-553, 1945.

thus challenged must have acquired immunity from the smaller doses of vaccines.

The types and strains of influenza virus used in this work, as is well known, act as cold hemagglutinins; hence, may be adsorbed onto red blood cells, then eluted off in proper sequence to effect purification and concentration of the virus by simple means. During this large-scale work we have adsorbed virus on red blood cells in the ice box and eluted it off at blood temperature routinely as the original preferred method of virus purification and concentration. A brief interim report of this work has been made.[4]

Since military use demanded a ten-fold concentrated influenza virus vaccine prepared from virus-containing periembryonic egg fluids, it is obvious that the yield per egg used must be rather small. Such eggs contain 5 to 10 cc. of fluid; hence, 0.5 cc. to 1.0 cc. of vaccine may be prepared from each egg. In work on a large scale we have averaged about 0.66 cc. of concentrated vaccine per original egg used. The "culture medium" therefore is rather high in cost.

LABORATORY ASSAYS OF INFLUENZA VIRUS VACCINE

We have conducted hemagglutination tests of numerous lots of raw influenza virus and also various lots of (adsorbed and eluted) purified virus, as well as formalin-treated vaccines resulting from these. Data on these tests are of some interest, but since they do not guarantee the immunizing action of the vaccine against active challenge virus, little is to be gained from study of such data. Suffice it to say that by the Hirst Technique our raw virus exhibits titers of 1-256 to 1-512. The specified vaccine exhibits titers of 1-1024 to 1-2048, or sometimes more. It is to be remembered that egg-passage strains of influenza virus are used to make vaccine, while mouse lung-passage strains are used for challenge doses in potency tests of vaccine. Obviously, the antigenic pattern of the vaccine must conform to that of the challenge viruses.

Since immunizing action of influenza virus vaccine (instead of various in vitro properties including hemagglutinating action, et cetera) has been accepted as an index of potency of vaccine for human use, the following immunity test results are described as examples.

Table I shows the extent of immunizing action of three current lots of influenza virus vaccine, types A and B, as made in the specified way in ten-fold concentrated form. These lots of vaccine were made on a large scale and comprised a total volume of over 700 liters, and therefore are representative of this product. Degree of immunization of mice (treated with doses of vaccine as stated previously) in these tests is such that none or one, two, and sometimes three mice of a group of six may die when challenged with 10^{-1} dilution of active virus. All other immunized mice usually live. The required immunity level is attained quite regularly, that is, 10,000 LD 50 resistance for type-A mice and 1,000 LD 50 resistance for type-B mice (which receive only one one-hundredth as much vaccine as type-A mice). Vaccine lots 386363, 386364, and 386365 easily pass the specified tests. Repetition of these tests of similar vaccine has been done thirty-five times during a period of a year and a half, and all these immunity tests cover the total amount of vaccine prepared as indicated above.

SUMMARY

The present report deals with influenza virus vaccine types A and B meeting present potency tests, and giving fair yields of the product as made on a large scale. All this vaccine is produced in embryonated eggs, and therefore a lot of meticulous labor is required for its preparation. No other large-scale quick method so far is known. This report does not bear on the effectiveness of the vaccine; however, additional information on efficacy should come from further field trials of similar laboratory-proved vaccine. It appears that in the interim between epidemics as thorough a preparation as possible should be made to anticipate the use of potent vaccine in the absence of more effective agents for the prevention of epidemic influenza. The present epidemic influenza virus vaccine is prepared on embryonated hen eggs, and like other vaccines prepared in this way (typhus, et cetera) is probably contraindicated in persons who are hypersensitive to eggs.

TABLE I

IMMUNIZING ACTION OF INFLUENZA VIRUS VACCINES AS TESTED IN SWISS MICE

DILUTION OF CHALLENGE VIRUS	Vaccine 386363						Vaccine 386364						Vaccine 386365					
	PR8 A		Weiss A		Lee B		PR8 A		Weiss A		Lee B		PR8 A		Weiss A		Lee B	
	V.*	C.*	V.	C.	V.	C.	V.	C.	V.	C.	V.	C.	V.	C.	V.	C.	V.	C.
10^{-1}	1/6**	.....	0/6	.....	0/6	.....	0/6	.....	0/6	.....	0/6	.....	0/6	.....	1/6	.....	1/6	.....
10^{-2}	0/6	.....	0/6	.....	0/6	.....	0/6	.....	0/6	.....	0/6	.....	0/5	.....	0/6	.....	0/5	.....
10^{-3}	0/6	.....	0/6	.....	0/6	6/6	0/6	.....	0/6	.....	0/6	6/6	0/5	.....	1/6	.....	0/5	6/6
10^{-4}	.....	6/6	.....	6/6	.....	4/6	.....	6/6	.....	6/6	.....	3/6	.....	6/6	.....	6/6	.....	6/6
10^{-5}	.....	6/6	.....	6/6	.....	1/6	.....	6/6	.....	6/6	.....	1/6	.....	6/6	.....	5/6	.....	3/6
10^{-6}	.....	1/6	.....	0/6	.....	.....	.....	1/6	.....	5/6	.....	.....	.....	4/6	.....	4/6	.....	.....

* VACCINATED MICE —V; CONTROL MICE=C.
**MICE DEAD/MICE USED; —SIGN=NOT DONE.

CONCLUSIONS

1. The available epidemic influenza virus vaccine is made from virus types A and B in equal mixture.

2. This vaccine immunizes susceptible Swiss mice very strongly, and the immunity produced is specific.

3. Such vaccine has made a creditable showing against rather mild influenzal disease in human beings, and against influenza produced by inoculation of active virus intranasally. No other influenza has appeared in the last two years.

4. It is not known whether the vaccine will prove effective in preventing epidemic influenza if this should appear in highly-virulent pandemic form.

5. If any forthcoming highly-virulent influenza should appear, and be caused by virus of types A or B, the present vaccine might be effective; on the other hand, the vaccine would have little or no chance of immunizing against influenza caused by viruses, et cetera, other than types A and B.

6. Since this manuscript went to press, information published by M. M. Sigel (*Science*, 1945, **102**: 646) and as an official note (*J.A.M.A.*, 1945, **129**: 1274) indicate that the present epidemic of influenza in the United States is due to influenza type B virus.

HYDROLYSATES—THE ANSWER TO THE PROBLEM OF NUTRITION*

CHARLES E. GILLESPIE, M.D.

SEYMOUR

Science which for half a decade has worked so earnestly in providing instruments of annihilation is now straining every effort toward repairing the ravages of war. Prominent in this effort is a new contribution to medical science that is being used to save the lives of perhaps millions of persons in Europe suffering from malnutrition. When starvation has passed a certain point, the ability of the sufferer to obtain nourishment from food ceases. Heretofore the unfortunate victim was doomed, but now, through the use of a new preparation consisting of a number of amino acids, the life of the victim can not only be prolonged but actually saved.

These amino acids have been shown to be valuable in saving the lives of many persons suffering in the late, heretofore irreversible, stages of starvation. Thousands, perhaps millions, of persons have died as a consequence of this war, because of inanition. After a certain point a fatal outcome cannot be avoided because the gastro-intestinal tract becomes incapable of functioning. Fluid or food cannot be swallowed or even given by a tube without causing vomiting or provoking diarrhea. For this reason, even though food were plentiful many more sufferers in Europe would die from malnutrition.

During a famine in India, in 1943, it was shown for the first time by Krisman and his co-workers that through an injection containing hydrolyzed protein and a glucose the rate of mortality was reduced considerably, even in late cases. It was found that the injection of glucose alone, of saline solution, plasma or blood proved relatively ineffective. Only a few injections, averaging three, of hydrolyzed protein solution proved necessary. After the treatment the victim revived sufficiently to be able to absorb food and liquids normally. Of five thousand injections, only a few untoward reactions were reported; none were serious. A papain digest of pork was used in preparing the hydrolysate.

After a certain period of malnutrition, the gastro-intestinal tract becomes unable to digest a sufficient amount of protein food. In some cases amino acids may be given orally, but in many cases this method will have to be supplemented, or even supplanted for a while, with intravenous administrations in order to be certain that a sufficient intake is taking place.

The addition of amino acids to the usual parenteral fluids makes possible, without recourse to the digestive processes, the administration of an almost complete diet. Starvation can be almost completely avoided. Limiting the parenteral diet to water, electrolyte, glucose, and vitamins is no longer justified; the addition of amino acids makes the mixture more nearly complete.

When because of malnutrition plasma proteins have become depleted, the use of transfusions have proved disappointing since the protein fails to remain in the blood, apparently as the result of an attempt to replace deficiencies throughout the body. In addition, repeated plasma transfusions, unlike amino acids, have led to reactions. In cases where the person is unable to ingest protein, amino acids may be given parenterally. Where an operation is contemplated, for instance, and where nothing by mouth can be permitted, in the presence of severe malnutrition parenteral protein will lower mortality. Again in cases of protein allergy, as from a bleeding peptic ulcer, the use of amino acids instead of whole protein will frequently prove effective.

The taste of many of the present commercial preparations is unpleasant. Attempts at flavoring the solution have not been entirely successful, but

* Presented at the hospital staff meeting of the Jackson County Schneck Memorial Hospital, at Seymour, on October 19, 1945.

a number of means can be used to partially disguise the taste. For instance, the use of twenty Gm. of a sugar solution as a chaser, or the use of tube feeding.

The mixture recommended for intravenous use is 5 per cent protein hydrolysate, 5 per cent glucose, and 0.2 per cent sodium chloride. The rate of injection cannot be too great, for it produces symptoms of nausea and vomiting. However, a two-hour period is really required for full utilization of the injected glucose and amino acids. A more rapid rate may be followed by loss through urine, but the amount has not been great even with one-hour injections. It is best administered one liter at a time—one in the morning, another in the afternoon.

Whenever there is failure in normal digestion and absorption of food protein, deficiencies develop at once unless supplied in some other way. Amino acids provide a practical method of preventing protein starvation. Any person who cannot assimilate food in the normal manner will suffer from protein starvation. Just as the universal use of solutions of glucose and saline obviates many deficiencies, the use of amino acids will prevent deficiencies in protein. The prevention of protein deficiencies is as important as the prevention of deficiencies of water, electrolyte, and vitamins.

Amino acids differ from vitamins in that they are more than catalysts or enzymes, but actually enter into the structure of the body tissue. While they are used up like glucose, they are not burned as fuel unless calorigenic elements are absent. There are twenty-one or more amino acids. Each is different, although there is a conformity of the general chemical structure. Ten of them may be considered not only essential, but actually indispensable, because the body is unable to manufacture them from other amino acids or from simpler materials, and they must be supplied before normal protein metabolism can occur. For example, normal growth will take place if these essential amino acids are fed to growing rats as the sole source of protein diet. Yet, if one were to be omitted normal growth could not be obtained. Thus, some of the amino acids assume an important comparison with the vitamins in the functioning of normal nutrition and life processes.

Amino acids are available in crystalline form, and may be purchased in the open market. They must be combined in the desired proportion and may be given to a patient either orally or by injection. The cost is great, and some mixtures contain both natural and unnatural isomers which are difficult to separate; natural proteins contain only natural isomers, although in some amino acids the two forms are equally utilized.

By using amino acids instead of food proteins, protein nourishment can be administered just as glucose is administered. Digestion and absorption by the gastro-intestinal tract does not have to be depended upon; parenteral administration may be used. Thus, even though these two functions may be completely impaired, protein starvation can be avoided. Protein-building substances can now be supplied as easily as salts or glucose.

A mixture of amino acids may be easily obtained by means of adequate digestion in vitrol of natural proteins. The procedures are similar to those by which the body produces amino acids from protein food in the gastro-intestinal tract. This method is both practical and cheap, but involves the possibility of losing some of the essential ones during the procedure of digestion and purification. The possible generation or introduction of foreign or deleterious substances during manufacture is another disadvantage. In addition, peptides, as well as amino acids, are present in the final mixture, but this appears to be of no practical significance. Pancreatic hydrolysis of casein contains the amino acids of casein and pancreatic tissue, two animal proteins of high biologic value. Their content of essential amino acids are not accurately known, but biologic tests show sufficient concentrations to support the growth of rats. Amino acid preparations produced by enzymatic hydrolysis contain 70 per cent of the potential amino acid nitrogen, the remainder being chiefly peptide nitrogen. With acid hydrolysis more nearly 100 per cent can be obtained in the form of free amino acids, although tryptophan is destroyed in the process and must be replaced. Protein hydrolysates containing amino acids and peptides when given in adequate amounts can maintain nitrogen balance and cause regeneration of serum proteins.

Each protein food has its own amino acid composition. Thus, transfers from one protein to another require a breakdown of the molecule into individual amino acids and the re-assembling of them to form another protein. The procedure is similar to the normal method by which food protein is transformed into tissue protein. Hydrolysis or digestion occurs in the gastro-intestinal tract with the resulting amino acids absorbed into the portal system and the synthesis of these building stones taking place in the liver and other tissues. Protein is constantly undergoing rapid and perhaps profound changes of various kinds. The concept that there are great masses of inactive protein stores will have to be abandoned. All protein tissue is in a constant state of chemical activity. In short, hydrolysates are combinations of various amino acids which build tissue and blood. Their mass production is regarded as important as the development of blood plasma and penicillin.

Amino acids are to protein what glucose is to starch. They are unit components of food and tissue protein. They are to be considered as one of the milestones in the development of nutrition. The isolation of these specific chemical components which enter into the metabolic activities of the body from food represents the most important recent contribution of chemistry in the field of nutrition.

ANTERIOR POLIOMYELITIS A COMPLICATION OF INFLUENZA

O. P. BIGELOW, M.D.

ROANOKE

The epidemiology of anterior poliomyelitis (hereafter called "polio" for brevity) has always been a puzzle. It is clearly an infection; yet how can we explain the appearance of only one case of the disease in a town or county? Where did the infection come from, and why did it not go farther? This is only one example of many oddities of distribution which have not been satisfactorily explained.

I believe that the explanation is very simple, that is, that polio is not a disease entity, as believed heretofore, but a *complication* in a very widespread disease—influenza. If we would take time to think it over, I believe that its erratic distribution would be completely explained.

In its onset, polio is influenza, as far as one can tell from the symptoms. If no paralysis appears it remains "influenza." If paralysis appears, the diagnosis is changed to "polio." With more frequent spinal fluid examinations being performed in late years, the finding of increased protein and cell count has resulted in many cases diagnosed as polio even though there was no appearance of paralysis. This diagnosis has even been stretched to cover other members of the family, sick at the same time with the same or about the same symptoms, but with normal spinal fluid—"abortive polio." Putting all these cases under the same label is the same idea as mine, except that the label is different. In time I believe that these cases will be labeled "influenza" with or without complications.

The nervous system is very susceptible to attack by the influenza virus. Almost every case shows some degree of neuralgia, neuritis, meningeal irritation, or mental derangement. Occasionally we see an outright influenzal meningitis. And about as often, or a little oftener, there is cord involvement. It has been the custom to immediately discard the diagnosis of influenza in its entirety in the latter case and shift it to infantile paralysis. But why shouldn't the influenza virus attack the cord at times as well as any other part of the nervous system? It would really be more surprising if it did not. Its affinity for the anterior grey matter is analogous to the preference of the syphilitic spirochete for the posterior columns.

The explanation for polio epidemics is simple. Different epidemics of influenza show a wide variation in the bodily tissues mainly attacked—lungs, bronchi, sinuses, intestines, peripheral nerves, or central nervous system.

All in all, I believe that a stricter quarantine of influenza cases would do more toward stopping a polio epidemic than dusting the town with insect-powder from an airplane.

ABSTRACT

PENICILLIN INEFFECTIVE FOR TETANUS

Tetanus, more commonly known as lockjaw, does not respond to penicillin treatment, according to W. A. Altemeier, M.D., from the Department of Surgery, University of Cincinnati College of Medicine, and the Cincinnati General Hospital.

Writing in the January 12 issue of *The Journal of the American Medical Association*, Dr. Altemeier said:

"A clinical study of sixteen cases of established generalized tetanus has failed to show evidence of any beneficial effect of penicillin on the course of this disease. There was no obvious fall in the temperature or pulse rates, as has been repeatedly seen in other infections susceptible to its action, no decrease in mortality or morbidity nor any definite decrease in the severity, duration, and frequency of the convulsive seizures which could be attributed to the action of penicillin. Exceptions may be found in cases of tetanus complicated by pneumonia or other infections susceptible to penicillin. In such instances, however, the improvement that occurs is due to the effect of the chemotherapeutic agent on the complicating infection, and not on tetanus."

Tetanus is an acute infectious disease of the central nervous system caused by a germ, called the Clostridium tetani, and characterized by painful spasms of the muscles due to the action of a toxin. Tetanus usually follows an injury, often trifling, but especially puncture wounds or lacerations of the hands or feet which have come in contact with the germ.

Dr. Altemeier said lockjaw occurs so frequently in small and often insignificant wounds because these do not receive a physician's attention. Patients with large wounds are immediately injected with tetanus antitoxin which prevents the poison from spreading.

In tetanus there is rarely any sign of infection at the source of the laceration or puncture wound. The bacteria produce a powerful toxin which spreads to susceptible tissues throughout the body. After a sufficiently large dose of the toxin has become fixed in the central nervous system, death apparently is inevitable under the present methods of treatment. Large doses of antitetanic serum, which are effective in the prevention of the disease, are of no use once poison has become fixed in the central nervous system.

Penicillin has not been beneficial in the treatment of tetanus because it has no effect on the Clostridium tetani toxin. Dr. Altemeier concluded that until some chemical agent can be found to directly attack the fixed toxin, successful treatment of the disease must depend largely on an early diagnosis.

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FEBRUARY, 1946

Editorials

THE SECRETARIES' CONFERENCE

This annual conference was held at the Columbia Club, at Indianapolis, on January thirteenth, with Chairman Mitchell presiding. Due to the inclement weather prevailing in some sections of the state the attendance was somewhat below normal; however, some 175 registrations were noted.

After some opening remarks by the chairman the program was taken up, with President-Elect Romberger rather briefly addressing the assembly, his "text" being that the Indiana State Medical Association is *your own* organization; the individual member is the state organization.

Dr. Frank S. Crockett, Chairman of the Committee on Rural Medical Service, of the American Medical Association, then addressed the group, detailing some of the results of conferences with Farm Bureau groups in many sections of the country. He stated that one of the larger problems is the hesitancy of the younger men of the profession to locate in the rural communities—they seem to want to locate in the larger cities. He said that his committee feels that it would be well for the county medical societies over the country to have immediate contact with the local farm bureau groups, which might aid in ironing out some of the present problems. He also cited a survey recently made in Georgia in this connection.

He made the statement, with which we are in entire accord, that a single plan will not fit every section of any state. The building of more county hospitals and the naming of full-time county health officers would be of incalculable benefit in solving the problems before the medical and farm bureau groups.

Jack Meadors, full-time executive secretary of the Bureau of Public Relations, of the South Carolina State Medical Association, discussed some of the problems that had confronted that organization. He stressed "the ten-point program" that had been evolved by Dr. Julian S. Price, secretary-editor of *The South Carolina Medical Association Journal*, these points having been printed in THE JOURNAL some months ago.

Mr. Meadors spoke extemporaneously, and since no reporter was at hand it is impossible to report exactly what he said. However, we have arranged to have him send us a copy on the subject, which will be printed in a later issue.

Dr. L. E. Burney, Executive Health Officer for the State of Indiana, discussed some of the matters that had been presented, declaring, "the State Board of Health problems are your problems."

The Board of Health plans a close cooperation with local groups, under the new setup, which means much for the future of Indiana in the matter of public health.

Dr. Glen Ward Lee, formerly Medical Director of the Indiana System of Selective Service, announced that he had been retired from that post, and took occasion to thank the members of the Indiana profession for the whole-hearted cooperation he had received in his work.

Dr. Walter U. Kennedy, of New Castle, Chairman of Committee on Prepayment of Medical and Surgical Care for Indiana, briefly discussed the present status of the problem. He said, "the form of such insurance is not the important factor, the main point being that we should do something." He stressed five points:

1. We assume no liability for the plan.
2. It is to be controlled by the medical profession.
3. The plan must be actuarily sound.
4. It must be adequately financed.
5. It shall be flexible.
6. It must be a non-profit organization. He asked that each county society secretary get busy and see that their members of the House of Delegates *act.*

Dr. Edward J. McCormick, of Toledo, of the Council on Medical Service and Public Relations of the American Medical Association, was unable to be present to take his place on the program, due to all planes being grounded at the Toledo Airport. Our own Tommy Hendricks, secretary of the above Council, did the pinch-hitting for Dr. McCormick, and did a "swell" job, to use his own pet expression. He outlined some of the work already done

by the Council, and hinted rather strongly what is in store for committee action.

Dr. Charles F. Thompson, recently of the Thirty-second General Hospital—the group from the Indiana University Medical Center, talked on some of the problems of the returning medical officer and what might be expected of his local medical society. He stressed the importance of each county group having a veterans' affairs committee.

A second speaker, unable to arrive because of weather conditions, was Dr. O. E. Wilson, of Elkhart, who was to speak on "The New Section on General Practice." We plan to publish his address in a succeeding issue, since it is a matter of very great importance at this time.

The evening session, with the principal address given by Major General Paul R. Hawley, Acting Surgeon General of the Veterans Administration, is covered in another editorial.

HERMAN G. MORGAN

In the passing of Dr. Herman G. Morgan, long-time Indianapolis Health Officer, Indiana Medicine loses another of its notable men. For more than thirty-three years Doctor Morgan served his native city as head of its health department. It is recalled that just thirty-three years ago the late Dr. John H. Oliver, then head of the Department of Surgery in the old Medical College of Indiana, asked Doctor Morgan, as a favor, to head the Board of Health, commenting that it would be for only a long enough period to get the organization properly framed. But after this had been accomplished there was a general demand, from citizens and physicians alike, that the genial, competent, and efficient health officer stay on the job, which he did.

Changes in city administrations made no difference; "Herman," as he was best known to his myriad of friends, kept right on the job—and he did just that, never faltering in what he believed was for the best interest of his city. For many years the "Morgan method" has been accepted as a criterion by which city health plans of many other cities were laid out and maintained.

He was graduated from the Medical College of Indiana in 1909 and soon thereafter planned surgery as his career, but three years later Dr. Oliver urged him to take over the post of health officer.

In this field he did an enormous amount of original work; after long years of trial he finally stopped the sale of raw milk in Indianapolis; and he was a pioneer in the matter of typhoid fever and smallpox immunization, being one of the earliest physicians to administer smallpox vaccination to school children, a procedure which in that day was opposed by many parents and frowned upon by not a few of his confreres.

During the late war he was instrumental in building up the Isolation Hospital, for the curbing of venereal disease, Indianapolis being one of the "plague spots" in that regard because of its location near two large Army posts. This institution was one of his "pets," and he was justly proud of the work done there.

Another "Morgan idea," one that he had no little trouble in putting through, was the merit system for all employes in his department. By continually plugging away at it he finally convinced administration folk that such a system was a health department necessity, and the old plan of changing employes with each new administration passed out.

"Herman" was generally known to members of the Hoosier medical profession, and until the past two years had been a regular attendant at all state conventions. At these gatherings, especially back in the days when the "smoker" was just that, his table was always surrounded by a large group, eager to hear his stories and even his casual conversation, for as a conversationalist he had few peers. He had a quaint sense of humor, almost to the droll point, and when he and "Bill" Herschel, who attended our annual gatherings as a representative of the Indianapolis *News*, got going the modern floor show was but a poor imitation of what these two men put on.

Doctor Morgan knew some time ago that "his number was up," but that did not deter him from carrying on his work until a very short time before he passed on. His last public appearance was about a month ago when he attended the exercises attendant upon the dedication of a new health center at Flanner House, this center bearing his name.

For many years he served in our House of Delegates, and in that capacity soon attained the reputation of being a man of conviction and a most worthy foe in the many debates in which he took part. He had a host of friends, both in his native city and over the state, as well as throughout the country. He will long be remembered as one who contributed much to the profession he loved.

THE VETERANS ADMINISTRATION

We know of few wartime subjects that have created more discussion in recent months than that of the Veterans Administration. Congress has had the subject before it on many occasions, as have administration officials, and at times it came near being a political football. Not so long ago one of the better known magazines with a huge circulation published an article on the matter which could not be overlooked; hence, radical changes were immediately brought about and new heads appointed. Accordingly, Hoosier-born Major General Paul R. Hawley, a man with an enviable record in the European phase of World War II, was named as Acting Surgeon General of the Veterans Administration, and it was this man who came back to his native state on January thirteenth, to address the Secretaries' Conference of the Indiana State Medical Association.

It was quite fitting that he should be introduced by our own Cy Clark, who served as a colonel in the Medical Corps, under General Hawley, in the various activities in Europe. General Hawley, after paying a beautiful and deserved tribute to the Thirty-second General Hospital, as well as its predecessor of the same title in World War I, wasted no time in getting into the heart of his subject. He said, "A large number of competent, conscientious physicians are already in the present setup, and it is with these I hope to build our organization. We face the problem of caring for some twenty million veterans of all wars." This statement gave some idea of the magnitude of his present task. He then went into some detail in explaining the various acts of Congress which have resulted in non-service-connected disabilities being cared for in veterans' hospitals. He found that 35 per cent of the cases in these hospitals were service-connected, and that 65 per cent were not. These figures are taken from the personal statement of the inmates of these hospitals.

He said that a decision must be made as to what policy we shall continue—"Shall we continue to accept nonservice-connected disabilities? One hundred fifty to two hundred thousand beds depend on the answer to this question."

He further said, "By the end of 1960 we will need three hundred thousand beds to care for service-connected disabilities; this means a staff of ten thousand doctors; eighteen to twenty thousand doctors will be needed if we take *all* cases." He suggested that it should be borne in mind that this means full-time service for these doctors, although he feels that part-time service of certain doctors will also be required to care for in-patients, and that a fee basis for physicians is fair and equitable for out-patient service. Local medical organizations are being asked to submit fee bills in this connection.

General Hawley said, "One of our future problems is to grade these hospitals according to the highest standard. At present we have ninety-seven such hospitals; we want at least 90 per cent of these approved for residencies. So far forty-five of our medical schools have agreed to cooperate with the Bureau, and we hope to have a larger number later on."

He discussed what he termed, "Public Law, No. 293," explaining many of its features. This enactment by Congress is not so familiar to the average practitioner, and the exposition by General Hawley was most timely. One feature that pleases most medical men is that doctors, nurses, and dentists are removed from control by the Civil Service. Another feature is that physicians will be paid on a merit basis, and not according to the number of beds in a hospital. Such was the case under the Civil Service. The law also permits the sending of these hospital physicians to their national and state medical meetings.

General Hawley gave a list of men of national medical repute, selected from the schools over the country, who will head up various departments and hospitals. This list reads like a medical "Who's Who," since it contains the names of men who were at the head of various medical school departments throughout the country.

After hearing the forceful, factual talk by General Hawley we are convinced that the affairs of the Veterans Administration henceforth will be conducted in a systematic, efficient, and workable manner. We believe that it means the disabled veteran will get better medical and surgical care than has been afforded in the past. General Hawley no doubt will employ the same course he pursued in his work in the European war area, where his name was synonymous with efficiency, based on a real knowledge of the job ahead of him. We have no fear for the future in so far as the Veterans Administration is concerned, for we know that the Medical Department will function one hundred per cent.

CONSERVATION OF NATURAL RESOURCES

Again referring to the matter of stopping the pollution of our Indiana waters, both lakes and streams, we are reminded of the present action of Purdue University, in calling a meeting on January tenth, concerning the industrial wastes which for so many years have been unceremoniously dumped into the waters of the state. This conference was primarily for the purpose of directing the attention of the offenders to the fact that this waste disposal all too often is being done at a loss to the plants concerned. For many years our engineers have pointed out that many of these industrial wastes have a marked commercial value, and that their utter destruction is a distinct loss to the company involved.

Some time ago we recounted the experiences of a large packing company, when one of its research chemists made a survey of the sewage that was being discharged into nearby waters. He found that a large per cent of this was grease and that its reclamation was to be had at a very small expense, but with much profit.

In reading a recent book concerning the old-time plantations down in Louisiana, when sugar cane was one of the standard products of the area, we learned that the refuse of the cane, after the juices had been extracted, were commonly poured into the Mississippi River. Later it was found that this so-called "refuse" had a large commercial value, with the result that now it is all processed and sold at a large profit. Again, the instance of lead refineries of some years ago might be cited; it was found that the smoke from these refineries, which was causing untold damage to the surrounding agricultural area, was being crated and distributed over the surrounding country at a great loss to the companies involved, since it meant a huge loss of

lead itself. Today, this "smoke" is being utilized at a profit.

So, it is hoped that this Purdue Conference will lead to the suggestion of many plans by which our present industrial wastes may be properly utilized and no longer dumped into our streams, there to continue as a menace not only to living creatures within these waters, but a distinct menace to the health of the population living along these streams.

Indiana's waterways long since have become famous; who has not heard of the "Banks of the Wabash," or delighted in hearing the song, "The Beautiful Ohio"? And many of our smaller streams, as well as our large number of lakes, have prompted the poet and the songwriter to pen lines about them.

Our Conservation Department, one of the best in the nation, has done much to popularize these bodies of water; state parks have been constructed in all areas of the state, with more being planned. In practically every instance these pleasure spots have been built around a natural water course, be it stream or lake, and in many instances artificial lakes have been created.

But even with all this information before us for so many years past, and with legislative acts, one after another, we must face the fact that the pollution of our natural waters has gone on and on, until in many instances these waters will not permit fish and other aquatic life to carry on. During our residence of several decades within this state, we have noted stream after stream that once afforded the amateur Isaak Walton plenty of opportunity for engaging in his favorite sport to become utterly void of living things.

But the future picture appears to have a different aspect; we now have enabling legislation—legislation with sufficiently sharp teeth to enforce the law. Further, we have a new setup in the way of a special commission for this purpose, and, best of all, one of our state universities is lending an able hand in the matter, so the prospects are that in due time we will be well on our way to better and cleaner waters. There is not one sound reason why our waters should not in time be restored to their natural state; we need this natural asset as sorely as we need many others with which the state is blessed; hasten the day when we again can look upon our waters with the pride we had in them in days gone by.

Dues become delinquent after February first. Pay your dues now!

Editorial Notes

President Truman has given his approval to the location of a two-hundred-bed general hospital to be built in the Fort Wayne area, according to an announcement by General Omar Bradley. However, it probably will be a year or more until the hospital is completed, since the site has not yet been selected nor have the plans been completed. This is one of several proposed hospital units to be erected at strategic points over the country as one of the means of properly caring for the injured veterans of World War II.

The Hoosier press continues to evidence the fact that it still favors the medical profession, rather than an indiscriminate system of caring for the ills of citizens of this state. The *Muncie Star*, under date of December 27, carries a most enlightening editorial on the Wagner-Murray-Dingell Bill, stating that while they are in favor of an extended hospital building program, they are not in accord with a bureaucracy-controlled system of medical care. Such a plan, the editor declares, would more than double the cost of medical care, thus placing an additional burden on the taxpayers.

The Bureau of Information of the American Medical Association has issued a pamphlet entitled "Information for Medical Officers," which should prove of much interest to that group, now that many of them are being discharged from service and are desirous of knowing just what is what. The bulletin discusses the G. I. Bill of Rights, going into some detail as to what this means in the matter of education, loans, et cetera. The former item, that of education, is quite fully discussed and will enable those interested to thoroughly understand just what its provisions mean. A copy of this valuable pamphlet may be had by addressing The Bureau of Information at 535 North Dearborn Street, Chicago 10, Illinois.

At the recent Secretaries' Conference we again had the pleasure of meeting a real patriarch of Indiana Medicine, Dr. William Lawson, of Danville. Doctor Lawson holds the distinction of being the same age as the Indiana State Medical Association—ninety-seven years. He told his audience that the Association was "born" in a "little white church, on the Circle, in Indianapolis." Doctor Lawson holds another record, that of having served as secretary of the Hendricks County Medical Society for a long, long time; in fact, since 1879. In spite of his age, Doctor Lawson continues the practice of the healing art in his home community, and we trust that he will be with us when the Indiana State Medical Association celebrates its one hundredth anniversary, in 1949.

Dr. George Obery, of Batesville, "got his picture in the paper," along with a write-up about a large bass he caught in Shafer Lake late last fall. According to the *Monticello Democrat*, of November 9, this fish measured 21.8 inches and weighed over five pounds. While not a record fish, yet one of this size is enough to make any fisherman happy.

An interesting tale filters through concerning a recent county-hospital election project in Adams County. According to the story, five Adams County physicians had signed a bond, prior to the election, guaranteeing the payment of half the cost of the election, in the event that the project was voted down, which it was. The election costs amounted to $1,701.30, so each of the five physicians have been billed by the Adams County auditor in the sum of $170.13. That is a rather pretty sum to be assessed those who sought a step that is progressive and essential.

Your state and county medical society dues became due on January first, and while hundreds of members have sent in their checks, there are too many delinquents at the present time. We would again remind these delinquents that their medical defense protection, so far as the state association is concerned, expires as of February first, unless their dues are paid prior to that time. Prompt payment of dues is of material benefit to the headquarters' staff, particularly Miss Reid, who handles all membership problems. If *all* dues were paid at the first of the year she could make the proper entries and mail out membership cards all in a few days. On the other hand, if dues come filtering in over a period of several months, it means a huge loss of time, in the aggregate. Get your check in to your local society secretary right now; that will help a lot. (We might cite the fact that a western state organization has set its 1946 dues at *$100.00 per year!*)

The shortage of nurses in the New York City hospitals has reached a most acute stage, as reported by Major LaGuardia and Dr. Edward M. Bernecker, Commissioner of Hospitals for the City of New York. It is stated that while the full complement of nurses in the various institutions reaches the huge total of 6,200, there are at present but 2,700 nurses employed therein, not a sufficient number to give any degree of adequate service to their large number of patients. The Mayor declares that as soon as nurses are discharged from the armed services they are "snapped up" by the Veterans Administration for service in those hospitals. One reason for this is the fact that the "entering pay" in the New York hospitals is $1,800 per year, while in the Veterans Administration hospitals the pay is $2,300 per year. The Mayor has asked that the city meet this salary increase else it cannot be responsible for adequate care of patients entering its hospitals.

The Lake County chairman of the National Foundation for Infantile Paralysis is quite concerned lest folk in that community confuse the present Sister Kenny Foundation Drive with that of the older organization. The Kenny group has distributed "cups," placed here and there throughout the territory, including the taverns, and patrons thereof are requested to drop their donations therein. The "March of Dimes" plan, as usual, will be used by the older organization.

A little incident, indicative of one of the many likeable things about the late Dr. Herman G. Morgan, was reported in the Indianapolis *Times* sometime before his death. It seems that the State Attorney General had made a ruling that a local health officer was legally entitled to retain the fifty-cent fee for issuing birth certificates, et cetera. In Doctor Morgan's case this amounted to over $5,000.00, over a period of several years. However, he long had used this money in keeping up the Statistical Division in his office and stated, "The city's paying me enough."

Montezuma, a sizeable town in west central Indiana, has been without a resident medical man for some time, and steps have been taken to remedy the situation. The local paper reports that a physician recently came to the town, planning to locate there, but being unable to find a place for his family, he located elsewhere. Later on another physician made two trips to the community, seeking a home and office space, and a local committee took the matter in charge. At this writing we have not learned whether this committee found a place for the doctor to live, or an office site. Such conditions also exist in many other states, as gleaned by looking over the various medical journals.

A considerable number of physicians attending the Secretaries' Conference expressed the opinion that this meeting, one of the most important in the association calendar, should not be held early in the year, at a time when inclement weather may reasonably be expected. There have been numerous occasions when meetings scheduled for midwinter have a limited attendance, due to transportation conditions; the recent conference was no exception. Several from the northern part of the state who had expected to drive down found the local highways a glare of ice. Train service to many of these areas is not what it used to be, and in such weather air service usually is discontinued. Doctor McCormick, of Toledo, one of the guest speakers who had planned to come by plane, found no planes leaving Toledo; hence, could not be present. The suggestion was made that since we are to have quarterly meetings of the Council, one to be in April, this would be an ideal time for the Conference. It is hoped that those in charge of arrangements for these meetings will take this matter into consideration in setting the dates for future meetings.

In line with the plan of the Indiana State Board of Health, Bartholomew County is looking into the matter of a full-time city-county health officer. The present setup is on a part-time basis, and much interest is being evinced by the local citizens in making this a full-time proposition, even though there would be an added cost to the present program. We may expect similar action to be taken by many other communities over the state, for it has been proved that a full-time health department in our county is well worth the investment.

The present state administration has introduced an innovation, one that is meeting with popular approval. They "take the state government directly to the home folks," this being accomplished by setting up a complete "State House" here and there over the state. The Governor and all department heads move in for a day or two, and invite the local citizenry to call upon them to discuss any problems they may have. This is but another—and most excellent—way of acquainting the residents of Indiana with what actually is done by all state officials, from the Governor on down.

Dr. Lee Forrest Hill, who for nine years past has served as editor of *The Journal of the Iowa State Medical Society*, has resigned that position, and the Board of Trustees have named Dr. Everett M. George, of Des Moines, as his successor. A graduate of McGill University, in 1931, he has been located in Des Moines since 1939. He also served in the Navy in World War II, with the rank of lieutenant. Doctor Hill rendered excellent service during his years as the head of one of our most progressive medical magazines, one that we looked forward to seeing each month. We wish Doctor George the same measure of success.

Citizens of Washington County are becoming disturbed about the hospital situation in that community. With enlistments in the armed services and with the death of some of their former medical men, there has not been too much medical care immediately available in that community. This, coupled with the fact that there is no hospital within the county, has added to the problem. Seymour and New Albany, both thirty-five miles away from the county seat—Salem, and Bedford forty miles away offer the nearest hospital facilities. Even these hospitals are well filled, and often it is impossible for Washington County patients to gain entrance therein. The Lions Club Hospital Committee has of late been busy circulating petitions, and have had practically no refusals when approaching citizens of that community. These petitions will be presented to the local Board of County Commissioners who will be asked to call a special election in the matter, and it is freely predicted that the outcome of such election will be the planning of a county hospital.

The Indiana State Medical Association's Bureau of Publicity, finding itself, for the nonce, fed up on its weekly discussion of what to tell Hoosier folk about their health and how to preserve it, devoted one of its recent sessions to a discussion of an old-time topic, "the Saturday night bath." This institution, as old as Indiana itself, continues to carry on, just as it did decades ago when it was carried out without the aid of any Brass Hat medical committee to supervise it. Several newspapers over the state have taken it up and added much to the discussion, notably the Indianapolis *News*, which quotes liberally from the Bureau release, ending with the comment: "Thus the state's leading medical authority has spoken. As for the individual and his bathing routine it might have added, 'let your conscience be your guide.' "

Press reports indicate that morphine addicts are put to it to find the "supply" they need, and that frequent thievery is attempted, one method being to break into the doctors' cars and rifle the medicine kit. We should be on the alert for these folk and leave no temptations in their path. These addicts have become very clever and think up some outlandish schemes to outwit the doctor. Recently a chap called us during the dinner hour, asking if he could meet us in the office right away, saying: "I will have to go to the hospital, and want to see a doctor immediately." Talking with him for a moment we recognized an almost-forgotten scheme that used to be tried, and advised the would-be patient that we could not meet him now or at any other time. We heard nothing more about the matter.

Dr. Will Thompson, long-time practitioner at Liberty, told us an interesting tale about our guest speaker, General Hawley, at the recent Secretaries' Conference. It seems that one winter day, back in the days when Indiana roads were not of the present concrete type and when huge ruts abounded therein, Doctor Thompson was making a country call and had just succeeded in extricating his car from a particularly bad spot in the road when along came a much younger physician. Doctor Thompson said that for such a young man he was quite a philosopher. He said, "You know, Doctor Thompson, I've just been thinking—my father and grandfather drove over these country roads through all seasons and through all sorts of weather; whether I want to remain here and do the same thing is a problem. If I stay here for forty years, I probably will have a little money to invest when I retire, but I will have the worry of investments before me all the time. I am seriously considering going into the Army. There, if I behave myself and apply myself, I will get some promotions in those forty years, and my retirement pay will enable me to live comfortably, without any special problems." And, as Doctor Thompson said, "By golly, that is just what he did—and now look at him!"

President's Page

I had hoped to be able to report in this month's issue of THE JOURNAL concerning the completed action of the Council and the House of Delegates with reference to the Health Insurance Plan, but at this writing nothing has been definitely decided. We are now more concerned than ever following President Truman's speech recommending a compulsory health insurance. It all adds up to one thing: regardless of what we think or do, our actions will not be weighed on the scales of fairness to our profession, and we will have to settle for the whip end. No physician regards the Wagner-Murray-Dingell Bill as anything but a long step toward socialized medicine, and all its viciousness, but regardless of what we think, the powers that be keep elaborating upon the different avenues of approach to their Eutopia—the complete regimentation of the medical profession. Sometimes I think there might be more than one approach to this situation.

Would it be possible that the explanations that are being sent to physicians all over the United States might include the general public, for the simple reason that if these programs are put over, the people are the ones that are going to suffer? And when the people understand how inefficient their medical and surgical care will be as compared with what they have been accustomed to, is it not reasonable to believe that they will rebel against such a program? My money would be on such action, for after all the public will be at the receiving end. Along this trend of thinking we must not make the mistake that has so often been made in great undertakings of mythology—building a beautiful mansion on sand, or constructing a roof without a firm foundation. This has been demonstrated in all ventures that have failed, be it medicine or any economic activity.

I sincerely hope that this will not be construed in the attitude of criticism, but as suggestions for the betterment of our position in the battle that is to come very soon, for we are all confused as how to fight this thing to the best advantage.

The medical profession is indeed opposed to any one group of men governing its actions, and I refer to the Surgeon General and the Advisory Council that he is to appoint, which will consist of sixteen members. He has the power to appoint, with respect to state or local areas, committees to aid in the administration of the act. He also has the right to hire physicians, dentists, nurses, and laboratory technicians at his own rate of pay. This includes only a few of his directives, but it is enough to make us all shudder. In fact, I doubt very seriously that the Surgeon General himself desires to assume such dictatorial powers.

I wish to take this opportunity to thank the members of the various committees for their favorable acceptance of their appointments, and I hope and firmly believe that you will all carry with your acceptance the feeling that these committees are the stepping-stones to the success of any president's administration. By all means go into action at once; get organized; and put forth every effort possible, for upon your shoulders rests a great responsibility, not only to our state organization, but to the American Medical Association as well!

J. E. Farrell

PROBLEMS CONFRONTING OUR MEDICAL SOCIETY*

CLEON A. NAFE, M.D.

President of the Indianapolis Medical Society for 1945

INDIANAPOLIS

When I assumed the office of president of the Indianapolis Medical Society, on January 1, 1945, the physical stamina of the members who were at home in private practice probably was at its lowest ebb. Approximately two hundred fifty members of this society were in the armed forces. We had struggled through three years of the war emergency, during which time many physicians had worked beyond that which their physical health justified. They had seen some of their members die without replacements. Yet, the doctors carried on. Few, if any, people in Marion County suffered because of lack of medical care. Weekly medical meetings were held. Excellent programs were presented, although at times the attendance was not large. During the year seventeen members of our society have died. Undoubtedly the lives of some were shortened by the war effort. Since V-E Day and V-J Day, at first slowly, but recently more rapidly, many of our members have returned from their services in the armed forces. On December 31, 1945, one hundred thirty-two had returned. To these men we say, "Welcome home!" We hope that the other members may also soon be back in private practice again.

As your president during the year, I can say that all of our officers have discharged their obligations faithfully. It has been a difficult year because so many doctors have been away in service. However, an executive secretary has been employed, an office for the society has been established, and a definite step has been taken toward getting a proper medical society building. Not as much has been accomplished as your officers would desire, but the affairs of the society are in good order. For your new officers I bespeak the earnest cooperation of all the members of this society. I can assure you that they are sincerely interested in the welfare of medicine and will serve you well. They have difficult tasks ahead and deserve your full support. With more of our members back in civilian practice, the medical society and its officers can do a better job.

During the war the practice of medicine has changed. New social, political, and economic forces are striving to transform it completely. The dislocation of many doctors by their services in the armed forces, their subsequent changes in location, and trends toward more complete specialization has given more ammunition to the social planners. It is, therefore, proper that every physician should consider the changes that are proposed and some of the reasons for these proposals. The years 1946 and 1947 may well mark great changes in the practice of medicine in the United States.

Since the advent of the New Deal in 1933 the social planners and economic theorists have been gradually increasing their zeal in an attempt to project the Federal Government into the control of the practice of medicine and regiment the physicians. Various bills have been introduced into Congress that would affect the practice of medicine. At first these efforts were insidious and their motives were more disguised, but now the politicians have become more bold. Finally, on November nineteenth, in his health message to Congress, the President of the United States has recommended certain specific health measures, and socialized medicine with all its waste and inefficiency—the one thing that we, as doctors, have opposed more than anything else—is dangerously near.

Never has American Medicine been confronted with a more serious challenge. At the recent meeting of the House of Delegates of the American Medical Association, in Chicago, these political and economic issues were the dominant problems discussed. At long last the House of Delegates of the American Medical Association has scrapped its traditional negative view-with-alarm attitude and formulated a positive, aggressive policy, boldly asserting the position of medicine, and has inspired new hopes for the future. They instructed the Board of Trustees to employ Public Relations counsel for the purpose of developing a better Public Relations Program for the American Medical Association. Without a dissenting vote the House of Delegates instructed the Board of Trustees and the Council on Medical Service and Public Relations to develop immediately a specific national health program with emphasis on the nation-wide organization of locally-administered prepayment medical care plans. Observers hailed these actions as providing a definite constructive program for American Medicine, and as a reply to, and an alternative for, President Truman's recent proposals and the Wagner-Murray-Dingell and Pepper bills.

In reviewing the five features of the message on health which the President recommended to Congress, the House of Delegates endorsed the first, third, and fifth proposals. The first is embodied

* Presidential Address presented before the Indianapolis Medical Society, at Indianapolis, on January 12, 1946.

in the Hill-Burton Bill for the extension of hospital and health facilities, when the need is shown, by the proper state and local authorities. In this determination the state and county medical associations should have a prominent part.

The third recommendation dealt with the development of a national research foundation. This was approved, but it was recommended that it be placed under a scientific board of directors rather than a director appointed by the president.

The fifth proposal is for compensation to the worker for the loss of earnings due to illness. The American Medical Association has consistently approved such insurance and reaffirmed its endorsement.

The second recommendation is for an extension of maternal and child health services. This is embodied in the Pepper Bill, which would tend to turn over to a federal agency the medical care of every mother in childbirth, and of children up to twenty-one years of age. This is an extension of the present EMIC program forced through Congress as a war emergency. When this was passed it was stated that it was necessary as a morale builder so that the boys would know that their families were cared for at home. Although most physicians were opposed to this bill, the medical profession cooperated with the government in carrying out the provisions of the law during the war emergency because of their desire to aid the war effort. Promises were made that this was just for the emergency, but now it is proposed to extend the services to all. The American Medical Association recommends the defeat of this bill, although it has always favored proper aid for the extension of maternal and child health services where such need can be shown. Many believe that this bill is even more radical than the Wagner-Murray-Dingell Bill.

The fourth proposal of the President, and the main feature of the Wagner-Murray-Dingell Bill, is the creation of a federal system of compulsory sickness insurance. The House of Delegates vigorously condemned this bill, and stated, "No one will ever convince the physicians of the United States that this is not socialized medicine. The Wagner-Murray-Dingell Bill is founded on the false assumption that the solution of the medical care problem of the American people is the panacea for all the troubles of the needy. This is the first step in a plan for general socialization, not only of the medical profession, but of all the professions—industry, business, and labor. Positive proof exists from experience in other countries that inferior medical care services result from compulsory health insurance. A program as outlined is enormously expensive, and it will result in greatly-increased taxes for the entire population of the United States. Voluntary prepayment medical plans now in operation in many parts of the United States, and which are rapidly increasing in number, will accomplish all of the objectives of this bill with far less expense to the people, and under these plans the public will receive the highest type of medical care without regimentation."

The Wagner-Murray-Dingell and Pepper bills must be defeated at all costs. I am sure that our local society will bear its proportionate share in that effort. We have valuable allies in the nursing profession—dentists, pharmacists, hospitals, and other professions. All of these have much at stake. Also, the public will be of great aid in defeating these bills when they realize the enormous cost, the many ramifications, the various limitations in the free choice of consulting physicians, and the terrific import of these proposals. The Woman's Auxiliary can be of great aid in giving the public a true picture of these proposals.

When one reviews the record of American Medicine, both in the private practice of medicine and in the Army, it is difficult to understand the reason for the sudden burst of interest by our political leaders in the problems of medical care. Under our system of the private practice of medicine our citizens receive the finest medical care of any people on earth. We are the healthiest nation. Life expectancy has risen to an unprecedented height, beyond that of any other country. Fine hospitals and teaching centers are the envy of the world. They are the mecca for students and many patients from distant lands. The record of the physicians in the armed forces recruited from the private practice of medicine and their corps of assistants has been one of the outstanding achievements of this war. The lives they saved near the battlefronts and the casualties which they have rehabilitated in the Army hospitals are living monuments of these fine achievements.

Now, at a time when the physicians at home are exhausted by several years of an unusually busy practice, and many of the civilian doctors are still not settled at home, these proposals for a form of socialized medicine are made by the economic theorists. They have seized upon this time because everyone is still in a state of confusion, and sane thinking has not developed to any great degree. What are the reasons given for this great haste in making such revolutionary changes in the practice of medicine, while our nation is still unsettled? There has been little complaint from the people of this country concerning the quality of medical care they have received.

The economists and political leaders make no complaint concerning the ability of our physicians and the type of medical care they are able to give the people. These leaders are usually well satisfied with the medical care they and their families have received, yet they speak of the high cost and the poor distribution of medical care. As a result of this they contend that there is a lack of adequate medical care for certain segments of our population.

Some of these planners speak very convincingly of their desire to aid in this problem. They say that physicians have recognized that it is proper for the government to aid in the care of the ill

when that illness becomes of catastrophic proportions. They point out that the care of the mentally ill and those with tuberculosis has become a recognized function of various governmental units. The political leaders say that the people are demanding a better method of preparing for the costs of serious illness, and that it is the function of our government to fulfill the requests of the people which it represents.

It must be remembered, too, that we have developed a high type of medical practice. With all its accessories, such as hospital and nursing care, it has become expensive. We have educated the people that all should have adequate care, and they have come to believe that almost anything can be accomplished by the medical profession if the right specialist is consulted. Consequently, when they become ill they do not want to be denied any of these services. When they can not secure them, it is only natural that they would turn to their government to give them that which they desire more than anything else—good health. Often newspaper and magazine articles picture the accomplishments of medicine as too miraculous. It is difficult for people to understand that there are illnesses for which nothing can be done, and they will spend all they have trying to prolong a life that is doomed.

ADEQUATE MEDICAL CARE

Recently it has been stated repeatedly that five million men, or approximately one-third of the draftees, were rejected because of physical defects. This has been used as an argument that medical care has been inadequate. However, these same people fail to state that the standards of acceptance into our Army were much higher than those of any other country, and that many of these rejected draftees were later accepted into the armed forces. They also failed to state that many of these defects have no relation to medical care. If children are nearsighted or astigmatic, adequate medical care demands glasses for correction; whereas the Army or Navy decides whether or not it wants such an individual. Little can be done for color blindness, loss of limb, allergy, hay fever, and many of the so-called "mental and nervous conditions," although with proper medical management the great majority of these people are integrated into useful employment in civilian life. Yet these and other similar conditions comprised a large part of the rejectees.

What is adequate medical care? That which is considered adequate by some physicians may be considered inadequate by others. For a common cold some physicians, believing in the self-limitation of certain diseases, advise rest, while others treat it energetically with various drugs and a variety of local treatments. In some illnesses one physician may advise surgery while another may consider it unnecessary and even ill-advised.

"Luxury medicine" is, of course, a factor in this problem. It has been interesting to note in the days of acute doctor-shortage, and shortage of other health facilities, what deletions could be made in a program of adequate medical care without any real hardship to the patients.

Doubtless many of our large hospitals and medical schools have been grievous offenders in carrying out unnecessary procedures of diagnosis. This encourages the medical graduate to use too many expensive diagnostic tests when a good history and physical examination would be much more enlightening and less expensive. Probably the majority of patients like more attention than is adequate. They demand more in the way of diagnostic tests than are needed, and usually are willing to pay for them. Often they are unwilling to accept a good general practitioner's diagnosis, and request the opinion of one or more specialist when all they need is the services of one good physician. Often they request hospitalization and special nursing care when it is not needed. All of this adds up to a cost of medical care that is higher than necessary. There should be no reason to deny a patient the opinion of different physicians, or any other luxuries, if they wish to pay for them and the services are available, but I would hate to estimate the cost of medical and hospital care for the people of this country if every person received all of the medical care the patient or his relatives and friends thought necessary. Economic barriers are the only potent limitations of some of these unreasonable requests.

Undoubtedly there are many cases in which the cost of medical care is unusually burdensome; yet there are methods already established by which most of these can be properly handled without upsetting our whole economic system. Some economists have stated that 14 per cent of the people are in the group that can not pay for needed medical care, yet cannot get it at government expense. It is a sad commentary that these should upset everything that is fine in a medical care program for 86 per cent in order to correct a problem of 14 per cent of the people. Many of these economists are fine people with good intentions, but they have an entirely different viewpoint than we have. Just as a specialist in medicine often looks at only one part of the body and ignores all the rest, so do these socially-minded groups center their attention on the specific disease (poor medical care for this small group) and forget about the rest of the people. Certainly as physicians we can somehow lead the way in seeing that this segment of the population can be properly cared for medically without upsetting a very satisfactory system already established for the remaining group. We must use already-established methods or devise new means to care for this group, because the people want aid in solving this problem.

DISTRIBUTION OF MEDICAL CARE

When we consider the question of the distribution of medical care, some real problems are apparent, and there are some trends in medicine that are of real concern. Even before this war there

was a definite trend toward an over-accumulation of physicians in the larger cities, and a definite need for physicians in the rural areas and smaller towns. The younger physicians were not attracted to these smaller areas because of the lack of attractive opportunities. No one can blame the physicians, yet this presented a real problem. Before the war approximately 30 per cent of all physicians were specialists, with an increasing variety of specialties. Specialties have developed within specialties, so that the original specialties of general surgery and internal medicine had been divided into various groups. Whether the trend toward ultra-specialization has gone too far is a debatable question. Certainly it has multiplied the difficulties for the patient in his attempt to secure medical care.

The war has given this trend toward specialization a great boost. The physicians who had a specialty rating, as shown by membership in special societies or approved by their specialty boards, were generally given a higher rank than the man in general practice, although their age and years of practice were the same. Once in the armed forces, the positions of importance which the specialists were able to attain were definitely better than those of the men who were general practitioners. In other words, the backbone of medicine in America—the general practitioner, the family doctor—got the short end of the deal.

Now that the physicians are returning to private practice there are trends that are alarming. Recently I was told by a physician from California that twelve thousand doctors had made application for license to practice medicine in California. He may have overstated the number, but even one-fourth of that number, added to the large number of physicians already in California, would represent an unhealthy concentration there, and the deprivation of some other state of needed physicians. In our state it is alarming to note what a large percentage of the returning physicians desire to specialize and locate in larger centers, while the small areas are left without an adequate number of physicians.

But who can blame these men in general practice? They have served the people well. They have worked long hours and often have been inadequately paid. They have often given their patients good medical care and sound advice only to have that patient whisked away to some specialist on the advice of some well-intentioned friend or relative. If the specialist's advice differed from that of the general practitioner, they usually believed the specialist, because the people have come to believe that he is the last word in the diagnosis and treatment of disease, even though the family physician's advice may have been more correct.

The general practitioners have had too little to say in determining the policies of organized medicine. Although they have comprised approximately 70 per cent of organized medicine, the majority of the important offices of various medical societies have been filled by specialists. It has been estimated that only about 25 per cent of these officers are men in general practice. In most of our larger hospitals the general practitioner has had his field of activity curtailed so that at times he is prevented from giving medical care that he feels he is properly qualified to render.

No one can condemn all of these trends. Medical diagnosis and treatment has become highly technical and very complicated. No one physician can expect to master the whole field. This trend has developed as a result of a real desire on the part of the leaders in medicine to develop a high grade of medical care and, in the public interest, to prevent an untrained physician from doing procedures he is not well qualified to do. Yet the practice of general medicine must be preserved, and the physician who chooses to remain the family doctor must play a more respectable part in the care of the sick and in formulating the policies of organized medicine. Traditionally, they are the backbone of medicine. They are the ones who can really influence the thinking, the voting, and even the very lives of their patients. They are the ones who must really supply the answer for a proper and adequate medical care program. Yet if present trends continue we may see the family doctor disappear almost entirely, and small towns and rural communities will turn to their government for aid in securing needed medical care.

Some may say that many of these problems do not pertain in our county society. Yet these problems confront American Medicine. Our county medical society is a large society, comprising in numbers approximately 0.6 per cent of all the physicians in organized medicine in the United States. We therefore should have a respectable part in determining the policies of American Medicine through our regularly-elected delegates. Likewise, we have an equal responsibility in vigorously supporting these policies and finding ways and means to solve the problems that confront organized medicine. We can do this most efficiently by doing the best job possible with the problems we face at home. The county medical society is the basic unit of American Medicine. It must be a forceful organization if it is to fulfill its obligations as such to its local community. Through its officers it should have a fine community influence. Its advice should be sought by all public or private organizations that in any way deal with the problems of public health. It should give that advice in the public interest and in behalf of better medical care for the people.

It has been charged that medical care problems have become too greatly dominated by lay groups. That is true, but it must be remembered that they, too, are vitally interested in these problems. It is their health that is at stake, and they pay the bills. Many of the leaders of these lay groups are fine people, and their intentions are usually good. However, their training and experience is often such that it does not qualify them to deal with problems of health. It is the responsibility of the physicians

to properly advise and direct these groups so that their enthusiasm for improving the health of the people will be of help rather than a hindrance in obtaining that goal. Because of his training and experience the physician is best qualified to direct these activities, and it is his civic responsibility to give that guidance. It is to be deplored that many physicians accept appointments on the boards of various societies interested in health problems, then fail to attend their meetings, and fail to properly advise them.

I believe that physicians should be more civic-minded and should be more adequately represented in all civic projects. They have a high degree of education, and their opinions are usually valued very highly. It has often been stated that the newspaper editor, the minister, and the physician are the most powerful individuals in formulating the public thinking of a community. Too often physicians shrink from these civic responsibilities. It would be safer now for medicine and the public, who have the most at stake, if we had more competent physicians as legislators in Washington. It would be well for all concerned if at all times there were a moderate number of doctors of medicine serving as legislators in our own state.

Because of the war effort and the great number of physicians serving in the armed forces, it was physically impossible for the physician at home to display as much interest as he wished in these public problems. Now that many of the younger men have returned, all of us will have more leisure time to devote to things outside the actual practice of medicine. But it is to the younger men we must look for future leadership. In behalf of your new officers and future leaders of this society, I urge that you make your local county medical society the organization in which you have the greatest interest. It is the most vital unit of organized medicine. Through your regularly-elected delegates to the state association and American Medical Association resolutions may be adopted, policies may be formulated, and Public Relations counsel may be employed for advice on a national or state basis. Yet the solution of these many problems must be through the efforts of all the doctors in every county medical society throughout the United States. It is in each local community that adequate medical care must be given, public health measures must be instituted, and the opinion of the voting public must be formulated. It is here the public relation job must be done by giving the people a better insight into the problems of medical care and public health. It is here the opinions of our political leaders must be formulated by the people of their community whom they know and respect.

The pressing problem now undoubtedly is the defeat of objectionable features of the Wagner-Murray-Dingell and Pepper bills. Many medical leaders believe that these can be defeated, but that it will be a terrific battle. Similar legislation introduced into the California legislature, at the request of Governor Warren, a highly-respected governor, was defeated last year. But it took a terrific fight by the physicians and their allied groups. Even if this legislation is defeated, there are trends of thinking among certain groups of our people that will probably lead our government to continue to dominate our lives, our business, and our profession more than most of us desire. These are world-wide trends, and in a democracy a government may be expected to reflect the opinion of a majority of its citizens and carry out its wishes. It may be that we cannot change these trends, but as a united organization we can modify them.

It is for this reason that I have reviewed some of these problems with which most of you are familiar. Every physician should be interested in these social, economic, and political problems, and I am confident that out of our combined effort, judgment, and modification of the future type of the practice of medicine we will be able to retain most of that which is good in the private practice of medicine.

History records that in all revolutions the physicians have usually fared better than the other professions. The same probably will be true in our present social and economic upheaval, for as long as there are human beings there will be sickness. When people are sick they will want a competent physician. When that physician renders good medical care, the patient will be grateful and will want the physician to be adequately compensated. It is our responsibility to keep the standards and the traditions of medical practice on a high plane, so that the physician will always merit this confidence and respect.

SCIENTIFIC FAIRY TALE

When Gerard Domagk was experimenting with prontosil, the first sulfa drug, and its effect on streptococcus infections in mice, his daughter cut and infected her hand. The only treatment then known was surgery, but surgery did not help and the doctors declared their inability to save her.

Domagk, snatching at a straw, decided to try prontosil, although it had never been used on a human.

Doctors and father waited tensely as the crisis came and went. Then, in true fairy-tale fashion, Domagk's daughter recovered—the first patient to be saved by the first sulfa drug, the daughter of the man who discovered it! —*Pageant.*

REPORT ON ACTIVITY OF COMMITTEE ON RURAL MEDICAL SERVICE OF THE AMERICAN MEDICAL ASSOCIATION*

F. S. CROCKETT, M.D.

LAFAYETTE

One problem of rural medical service is caused by the hesitancy of young physicians to locate at a distance from medical centers where good diagnostic facilities may be found. This, when coupled with the advancing age of those remaining in the villages and smaller towns, gives rise to fear that country people will soon be, and in many places now are, without local medical care.

Legislators in our national capital are quite aware of this situation and are seeking through proposed legislation to provide for this emergency in response to the repeated urging from their constituents. This is not a recent phenomena. It has been developing for many years, but the crisis has become more acute because of the fact that during the war years many doctors, often the only one in the community, entered the armed services and now seek new locations more satisfactory for professional practice. This is not a local situation; it exists in nearly all the states.

The American Farm Bureau represents nearly a million farm families in some forty-four of the forty-eight states. The Associated Women of the American Farm Bureau is an auxiliary composed of the wives of the bureau members. These good women have been deeply concerned with the health problems of their families, and the prospect of no doctor within reasonable distance has stirred them to action. They propose to do something about it. Last spring they appealed for counsel from the American Medical Association, and the Board of Trustees appointed a Committee on Rural Medical Service. In July we met with a like committee from the bureau. We discovered, among other things, that the Farm Bureau, like our American Medical Association, is not organized to work on a state or county level. That must be done by state and county bureaus. It was agreed that both organizations should invite the component state groups to appoint rural health committees to cooperate in the exploration and solution of local health problems.

The American Farm Bureau is opposed to federal health legislation of a compulsory type and has appeared to testify against such pending legislation as the Wagner-Murray-Dingell Bill. In the Hill-Burton Bill they insisted on its local administration in matters of local interest.

The Hill-Burton Bill, which has been approved in principle by the American Medical Association, is also favored by the bureau, especially in its possible effect on rural medical practice. It seems reasonable to believe that the development in rural communities of centers where diagnostic aids together with public health and other kindred activities could be housed would attract well-trained physicians. It seems quite possible that federal legislation of this kind, administered largely on a local level, could be instrumental in improving the quality of medical practice in rural America without placing the profession in a legislative straitjacket.

At this conference it was agreed that if one or more counties could be encouraged to establish diagnostic centers the experience gained would be helpful in developing needed facilities elsewhere. Georgia has published a "Public Health Program." This is a most extensive and complete survey, covering the period 1940 to 1944. We should have one like it in Indiana. It covers urban as well as rural needs, facts that must be had if legislation of the Hill-Burton type is to be administered intelligently. Counties are not necessarily the unit for planning facilities and the factor of need. The number of those to be served, living within easy reach of the facility, must determine its usefulness. The Hill-Burton Bill speaks of diagnostic centers or health centers. It is not clear just what is meant by these terms. The Georgia survey proposes five types. For the smallest there would be health centers which would house medical, dental, and public health personnel, and be equipped with a small laboratory and fluoroscope. Next larger would be shelter health centers where in addition to laboratory and x-ray there would be beds for emergency and obstetrical cases; the number of beds being 1 to 1.5 per 1,000 population. In a county of 15,000 this would mean fifteen to twenty-one beds. This type facility could accommodate uncomplicated cases and might also serve the convalescent patient after leaving the general hospital. This would to some extent relieve the crowded condition of the general hospital and have the advantage of shortening the stay in the hospital and placing the patient nearer home and friends, and in the care of his family physician. With facilities of this type the rural practitioner should have available many of the diagnostic facilities and an opportunity for consultation enjoyed by those near well-equipped hospitals.

It might appear that the supplying of well-qualified physicians and adequate diagnostic and hospital facilities would be sufficient, but there are other factors that enter into rural health prob-

* Read before the Secretaries' Conference of the Indiana State Medical Association, held at the Columbia Club, at Indianapolis, on January 13, 1946.

lems. Point number one of the fourteen-point program for medical care calls for suitable housing, providing protection from cold and moisture, with proper sanitary provisions. This applies to some country homes which are not fit to live in; clothing appropriate for the protection of the individual; balanced diets suitable for the promotion of healthy growth in the young and maintenance of vigorous bodies in the mature; and a knowledge of better living habits, including instruction for expectant mothers on infant care, and home management of common ailments and first aid. All this means better health education and an appreciation which it is the duty of the individual to learn if the presence of a physician in the community is to have full effect.

Lay health education is a necessary part of any plan, and the Farm Bureau Committee recognized its duty in this regard, at least toward its own members. Without such a program the presence of the best-trained physicians is only partly effective. While the American Farm Bureau could speak only for its own members, it recognized that any plan to be successful must enlist all the elements of the community to be served.

Prepayment plans for medical care and for hospitalization have the approval of many farm groups. In other states where the plans are in operation, farm groups are being invited to join. The average well-to-do farmer is no problem, but the marginal farmer is a problem. Some solution for his special problems will eventually be found, without doubt. Each county will present some special problems not common to all.

In our own State of Indiana we have spent several years studying and discussing prepayment plans, and still have to take final action. During this period of indecision the Indiana Farm Bureau has had no trouble organizing its own indemnity type of prepayment budgeting for catastrophic illness. This shows a very evident demand for this sort of thing by farm people and, we are assured, need not interfere with our profession developing its own plan.

Tying in with the program of the Committee on Rural Medical Service is the very important work of the American Medical Association Bureau of Information. I doubt that many of you have had your attention called to this effort, to assist the returning veteran. "The aims of the bureau are to provide veteran medical officers with information concerning educational opportunities, state licensure, and medical, social, financial, economic, and other phases of community life that will enable them to make a selection of a location in which to practice medicine. The bureau is not meant to be a placement or employment agency. After returning physicians have been given all available information by the bureau, they are referred to state, county, and local medical society committees." (Committee on Post-War Medical Service report to House of Delegates.) This bureau has been able to collect an immense amount of data, although 500 out of the total of 3,200 counties in all the states have failed to co-operate, and in only about fifteen states have they gone all-out in supplying information asked for. This Bureau of Information is developing the facts needed in the solution of rural medical service.

The organized profession has a duty in regard to helping communities now without resident doctors. We must do our part in advising them. Some communities asking for doctors are too small numerically or lacking economically, or are near enough to other communities where the social life and economic opportunities are adequate to attract well-qualified doctors.

If the lack of diagnostic facilities and the remoteness of consultants are the factors that make young doctors reluctant to locate in our small towns, then we must find an answer to these.

The first requisite to right action is adequate information, and this the Bureau of Information has gone far to supply. Doctors cannot be assigned to any location. They must be attracted to the places needing them. It is recognized that the social environment is an important factor, as is the opportunity to earn a satisfactory income. Assuming that these conditions are met, what else could any community do to attract the right kind of doctor? When we speak of a community we should think in terms of 10,000, 15,000, or 20,000 people. If this embraced a single economic or political unit, such as a county, it would help our planning. With good roads and cars, an area taking in ten to fifteen miles in all directions would not be too big. The doctor would be within twenty to thirty minutes of everyone.

If we could get the voters of such a county so imbued with the benefits to be derived for themselves and their families that they would willingly tax themselves the relatively small amount needed for construction and maintenance, what concrete plan would we present to them? The construction by the county of a building wherein may be housed a clinical laboratory; an x-ray; a full-time public health office with an adequate nursing staff; public health supervision, such as immunization, communicable disease control, control of food-handlers, eating places, tourist and vacation camps, sewage disposal, and other public health activities, and where doctors' offices and dental offices might be housed, would go far in placing the practice of medicine in rural communities on a satisfactory level.

The presence of a diagnostic laboratory and x-ray equipment would require an all-time laboratory technician who would also be able to take x-ray films of the kind that should be undertaken in a place of that size. When consultation is needed, a pathologist or roentgenologist can always be found at some distance through the mail or contacted directly. It would be expected that these small centers would not compete with the hospitals.

but rather complement them by handling conditions of a less serious nature.

If beds for emergency or obstetrical cases were added, then a certain amount of hospital personnel must be included. Some provision for feeding, routine nursing care, and some special set-up for the delivery room must be made. In this contemplated facility for small communities only the most minor emergency surgery and uncomplicated deliveries should be attempted. It is not a lower quality of care, but a more local and convenient high-grade care that such centers should provide. Such centers must accept inspection from time to time as to quality of equipment and of professional care given if they are not to be put to uses beyond their capacity or intended usage.

Our own State Committee on Rural Medical Care has not been able to meet with a like committee from the State Farm Bureau. It is hoped that this can be arranged in the near future. With the imminent emergence of the Hill-Burton Bill, we should be prepared to play our full part in its application to community needs within our state. The county medical societies will be called upon for sound professional advice. The secretaries of county societies must see that our profession is not accused of obstructive tactics when asked to cooperate. It would be wise for each one to secure a copy of the Hill-Burton Bill as finally approved, and familiarize his society with its provisions.

FELLOWSHIPS IN PUBLIC HEALTH AVAILABLE TO VETERANS

The Indiana State Board of Health will make available a limited number of fellowships to physician and nurses who desire to acquire field experience and academic training which will qualify them for full-time civilian public health positions in Indiana.

Dr. L. E. Burney, State Health Commissioner, states that three to six months of field experience will be provided, followed by an academic year in a school of public health leading to a Masters Degree in Public Health. Fellowship provisions are generous and include tuition. Individuals completing this training will qualify for appointment to positions with the Indiana State Board of Health or with local health departments.

Physicians must be graduates of a medical school approved by the American Medical Association, must have had an internship of at least one year's duration in a general hospital approved for internship by the American Medical Association, and must be eligible for licensure to practice medicine in Indiana. Individuals with the above qualifications and who are not more than thirty-five years of age will be considered.

Nurses to be eligible for fellowships must be able to meet the matriculation requirements of universities that offer courses in public health nursing approved by the National Organization for Public Health Nursing, and must have satisfactory references from former employers. Nurses who have had some years of experience beyond graduation from training school will be given preference.

To meet minimal needs three hundred additional nurses will be required in Indiana.

All applicants for fellowships must be citizens of the United States.

Interested individuals should write to Dr. L. E. Burney, State Health Commissioner, Indiana State Board of Health, 1098 West Michigan Street, Indianapolis 7, Indiana.

ABSTRACT: NEW OINTMENT FOR PREVENTION OF SUNBURN

A petrolatum compound, developed as a result of wartime research, has been found to give excellent protection to the skin against long exposures to the sun. According to an article in the January 5 issue of *The Journal of the American Medical Association*, the sunburn ointment is not irritating to the skin nor will it come off easily in water.

The experiments were made under the direction of Matthew Luckiesh, D.Sc., of the Lighting Research Laboratory, General Electric Company, Nela Park, Cleveland. He was assisted by A. H. Taylor, and two physicians., H. N. Cole and Torald Sollmann, from the Department of Dermatology and Syphilology, and the Department of Pharmacology and Experimental Therapeutics, of Western Reserve Medical School.

The authors said that dark red veterinary petrolatum was the safest, most practicable, most cohesive and nontoxic agent found in their search for a protective skin coating for the prevention of sunburn.

The research was undertaken in behalf of the Army Air Forces, which needed a protective cream or ointment for fliers forced down in the Pacific area. The product had to withstand heat and cold, be free from rancidity, lend itself to simple packing, be nontoxic and not wash off. These requirements made it possible to place the ointment on life rafts or military aircraft.

In explaining their method of testing, the authors wrote: "The [ultraviolet light] exposure of ten seconds on the subject, without any protection, produced a moderately strong erythema while a twenty-minute exposure produced no visible erythema when the same subject had a thin coating of the compound. This exposure was equivalent to twenty hours of the strongest sunlight in Cleveland, measured during a four-year period. It is quite evident that this petrolatum alone, with nothing added, would give ample protection to the skin. Moreover, the petrolatum rubbed into the skin of one of us several nights in succession gave no evidence of irritation."

Six subjects were used in these experiments with an ultraviolet source intensity equivalent to sixty times the most intense sunlight measured in Cleveland over a period of years. One minute of exposure to this source is comparable to about two hours of average midsummer noon sunlight in Cleveland.

NATIONAL CONFERENCE ON MEDICAL SERVICE

19th Annual Meeting

Sunday, February 10, 1946

PALMER HOUSE, CHICAGO

9:00 a. m.	Registration, fourth floor, entrance of Red Lacquer Room.
9:30- 9:50 a. m.	President's Address, "*Medicine and the National Crisis*," C. L. PALMER, M.D., Pittsburgh.
9:50-10:20 a. m.	"*What Labor Expects from Medicine*," NELSON H. CRUIKSHANK, Director, Social Insurance Activities, A. F. of L., Washington, D.C.
10:20-10:50 a. m.	"*What the Farmer Expects from Medicine*," J. S. JONES, Secretary, Minnesota Farm Bureau Federation, and Chairman, National Committee for Rural Health, St. Paul.
	Discussion: LEONARD W. LARSON, M.D., Member of Committee on Rural Medical Care, American Medical Association, Bismarck, North Dakota.
10:50-11:20 a. m.	"*What Industry Expects from Medicine*," HOWARD STRONG, Secretary, Health Advisory Council, Chamber of Commerce of the United States, Washington, D.C.
11:20-12:00 noon	Open Discussion.
12:00- 1:45 p. m.	Luncheon.
1:45- 2:15 p. m.	"*Medical Care of Veterans*," MAJOR GENERAL PAUL R. HAWLEY, Chief, Medical Service, Veterans Administration, Washington, D.C.
2:15- 2:30 p. m.	"*Aims and Purposes of Conference of Presidents and Other Officers of State Medical Societies*," ANDREW S. BRUNK, M.D., President of "Conference of Presidents and Other Officers of State Medical Societies," Detroit.
2:30- 2:45 p. m.	Questions and Answers.
2:45- 3:00 p. m.	"*What About Returning Medical Officers?*" "*Postgraduate Opportunities*," VICTOR S. JOHNSON, M.D., Secretary, Council on Medical Education and Hospitals, American Medical Association, Chicago.
3:00- 3:15 p. m.	"*Establishment of State Bureaus of Information*," MRS. M. VIRGINIA SHULER, Supervisor, Bureau of Information, American Medical Association, Chicago.
3:15- 3:30 p. m.	"*Medical Legislation*," J. W. HOLLOWAY, Jr., Director, Bureau of Legal Medicine and Legislation, American Medical Association, Chicago.
3:30- 3:50 p. m.	"*National Plan for Voluntary Prepayment Medical Care*," JAY C. KETCHUM, Executive Vice-President, Michigan Medical Service, Detroit.
3:50 p. m.	Discussion.
	Adjournment.

Indiana is host to the National Conference on Medical Service this year. Dr. Cleon A. Nafe, of Indianapolis, is the Secretary, and we are looking forward to a good attendance from Indiana. Make your reservation now!

Military News

Dr. Joseph M. Siekierski, a Gary physician, has returned after three years overseas' duty, and has resumed his practice there.

Dr. Arthur E. Moravec, of Fort Wayne, has resumed the practice of medicine in his former location after being away two years in the Navy Medical Corps.

Another Indianapolis physician who has resumed his practice is Major John W. Graves. Major Graves served for almost three and one-half years with the United States Army.

Colonel Don G. Hilldrup, of Indianapolis, was assigned to Fort Sill, Oklahoma, on December fifteenth. He was formerly with the headquarters of the Sixth Service Command, Chicago.

Dr. Nathaniel C. Isler, of Jeffersonville, has returned to civilian practice after being stationed for more than a year in the Aleutians, as well as at various posts in the Continental United States.

Captain Herbert L. Egbert, of Indianapolis, is practicing medicine with his father, Dr. Roy Egbert, following his release from military service with the Army.

Since being released from military service, Captain Joseph J. Spalding, of Indianapolis, has taken a residency in ophthalmology at the City Hospital. Dr. Spalding served with General Stilwell's Army in China.

Charles W. Olcott, M.D., of Aurora, has returned following long service in the Pacific, during which time he merited a high award, the Navy's Legion of Merit. He plans to continue practice in Aurora.

James P. Gilliatt, M.D., of Salem, has resumed practice in his former location. He was on duty in the ETO with Patton's Third Army, serving as commanding officer of a medical battalion with the 95th and 97th Divisions.

Having received his discharge, after serving as a lieutenant colonel in the Army Medical Corps, Dr. Harry M. Covell has opened a temporary office in the Auburn State Bank Building; he is planning to move into a new building in Auburn as soon as it is completed.

Dr. L. B. Hurt, of Indianapolis, has recently been placed on inactive duty by the United States Navy, in which he served as a commander for more than three years.

Following two years' service in the Atlantic and Mediterranean areas, and one year in the Pacific Theatre, Commander Maurice V. Kahler has resumed his practice in Indianapolis.

Following more than three years of service in the Army Medical Corps, Dr. David F. Stone, of Indianapolis, has rejoined the medical staff of the Marion County Tuberculosis Hospital at Sunnyside.

After sixteen months in the European Theatre, Captain Lullus P. Muller, of Indianapolis, was redeployed to the Pacific, and then was discharged at Camp Atterbury on November eighteenth.

Another North Manchester physician, Dr. C. Eugene Cook, has resumed his practice of medicine there. Lieutenant Cook had served with the Army Air Force Medical Corps since August, 1942.

Information has been received at THE JOURNAL office to the effect that Dr. Herbert A. Schiller, of South Bend, is returning to practice there, following his recent release from military service.

Dr. Walter W. Meade, of Bicknell, has returned to civilian practice after forty months of service. He was on duty as a major with the Second Infantry Division and the 389th Combat Engineers.

Following his recent release from the service, Dr. Clarence H. Marchant, formerly of Bloomington, is now taking a postgraduate course in the University of Pennsylvania, Philadelphia. Dr. Marchant carried the rank of captain in the service.

Following five years' service in the Medical Corps, Dr. Francis P. Jones has entered the practice of medicine in Indianapolis. He served as a Lieutenant Colonel, and spent four years with the Second Army headquarters at Memphis, Tennessee.

Another veteran of the Southwest Pacific, Dr. Oliver R. Wilson, of Indianapolis, has opened an office there for the practice of general medicine. Captain Wilson saw service in the Christmas Islands and Okinawa, having served overseas for thirty-nine months.

Dr. J. R. Ware, of Huntington, has returned after three and one-half years with the armed forces in the Pacific Theatre, as battalion surgeon and collecting company commander. He has resumed private practice.

During his Army career, Dr. B. J. Smith, of Kingman, was a flight surgeon, and served for twenty-four months in England, France, and Belgium. He has resumed practice in the same office.

After twenty-one months' service in the South Pacific Theatre, Lieutenant Commander Thomas W. Reul, of Indianapolis, was discharged in November and has returned to practice in Indianapolis. He entered the Navy in June, 1942.

Dr. John C. Drake, of Anderson, has returned there to resume practice after almost four years of duty with the Navy. After serving for a year in the Philippines, Doctor Drake returned to the United States a short time ago.

Dr. Benjamin V. Klain, of Indianapolis, has returned to medical practice after forty-one months of Army duty, including a year's service as a staff member of the 236th General Hospital, near Epinal, France.

Captain Leo Kammen, of Indianapolis, has also resumed his practice there, after three and one-half years in the Army. Captain Kammen was a flight surgeon attached to the Eighth Air Force, and was in England for eighteen months.

After serving in North Africa, Italy, and British New Guinea for twenty-five months, Captain Charles H. Maly, of Indianapolis, has returned to private practice. He was in service for forty-one months.

Announcement has been made by Dr. Dale D. Dickson that he has opened an office in Greensburg for the general practice of medicine. Doctor Dickson was on duty with the Army Air Corps for many months, his last station being the Muroc Army Air Field, Muroc, California.

A new Army post has been given to Lieutenant Colonel Ralph C. Eades, of Valparaiso, who has been appointed as chief army medical officer for the states of Mississippi and Tennessee, with headquarters at Nashville, Tennessee.

A major in the Medical Corps for thirty-six months, Dr. Albert F. Gregg, of Connersville, has now returned to his former practice. Doctor Gregg spent fourteen months in England and France, and upon his return to the United States took a three months' course in anesthesiology at Fort Dix, New Jersey.

Dr. Richard B. Stout, of Elkhart, has resumed his practice there, following his recent release from service in the Army Medical Corps, where he carried the rank of major.

Upon being released by the Army, Dr. Kenneth G. Hill, of Washington, is taking a residency at the St. Elizabeth Hospital, in Lafayette, before entering private practice.

Dr. Frederic W. Taylor, of Indianapolis, has also returned to private practice, devoted to general surgery, following three and one-half years in the service, with eighteen months of sea duty. Dr. Taylor served with the rank of commander.

After serving in several Army hospitals in this country, Dr. Lacey L. Shuler, of Indianapolis, spent eighteen months in England, making a total of three years' Army service. He has resumed practice in his former location.

Announcement has been made of the association of Dr. Arthur E. Blazey with Dr. E. Brayton Smoot, in the Williams Building, Washington. Dr. Blazey has recently returned from the service, where he carried the rank of major.

Another veteran, Major William A. Shuck, of Madison, has returned to his home following release from the Army Medical Corps. Doctor Shuck spent sixteen months in New Guinea, two months in the Philippines, and two months in Tokyo.

Major William M. Browning, of Indianapolis, was discharged November twenty-eighth, after more than three years in service. A divisional medical instructor and medical battalion commander, Major Browning saw three hundred days of combat duty, and spent a year and a half in Italy.

After nineteen months' service in the South Pacific, and sixteen months' shore duty at Newport, Rhode Island, Lieutenant Commander Louis T. Need, of Indianapolis, has again become a civilian, and has announced his return to private practice.

Even though he is faced with the current problem of having no office space, Dr. George F. Green, of South Bend, is planning to resume practice forthwith. Doctor Green, a lieutenant colonel, served in the European Theatre, and was gone for thirty-seven months.

As regimental surgeon of the 22nd Infantry Regiment of the 4th Division, Major J. M. Kirtley, of Crawfordsville, was in the battles staged near the Moselle River, in Luxembourg, and particularly in the Huertgen Forest. Major Kirtley has now returned home after four years of Army duty, and has re-established his office in Crawfordsville.

In service three and one-half years, three of which were spent in Iceland, Major W. Donald Close has returned to Indianapolis, and has resumed his practice in Internal Medicine, at 809 Hume Mansur Building.

A Marine doctor, Commander Robert W. Phares, of Greentown, was released on November twenty-first after more than four years' active duty. Commander Phares was on duty with the Fourth and Fifth Marines in the Pacific, and he saw much action.

Serving as chief of surgical service in the 163rd General Hospital, just outside London, Lieutenant Colonel Dennis S. Megenhardt, of Indianapolis, is also consultant in surgery for the United Kingdom. He has been overseas for more than two years, and reports that he is anxious to return home.

The first Henry County doctor to enter service, Lieutenant Colonel G. E. Iterman, of New Castle, has returned home. Entering the Army in March, 1941, Colonel Iterman has been stationed at several posts in the United States, the last two years being spent as commanding officer of the hospital at Fort Stevens, Oregon.

One of the younger members of the profession to return to civilian life is Captain William M. Kendrick, of Indianapolis. He plans to enter general practice, but has not yet opened an office. Captain Kendrick was in service three and one-half years, and was on Guam for eleven months. He returned home in August.

Formerly a staff member before his entry into the armed forces, Dr. Orva T. Kidder has become assistant medical director of the Irene Byron Sanatorium, near Fort Wayne. Doctor Kidder participated in the African and Sicilian campaigns where he was incapacitated and returned to the United States. After his return he was stationed for some time at the Crile Hospital, in Cleveland, as a member of the staff.

Also a veteran of World War I, Dr. Fred N. Daugherty, of Crawfordsville, has resumed practice after almost four years of service in World War II, two of which were spent in the Mediterranean Theatre of Operations. During these two years he served in North Africa and Italy as chief of surgery with the 80th and the 105th Station Hospitals. Doctor Daugherty served with the rank of major.

Lieutenant Colonel Russell J. Spivey, of Indianapolis, has been released from service and returned to practice. Colonel Spivey was in service for more than three and one-half years. He was base surgeon at Baer Field, Fort Wayne; chief of consultation services at the Don-Ce-Sar Convalescent Hospital, St. Petersburg, Florida; and base surgeon at the Sarasota Army Air Field, Sarasota, Florida.

Dr. Robert A. Hedgcock, of Frankfort, who recently reverted to inactive status after having served as captain in the Army Medical Corps, has resumed the practice of medicine.

A former Navy flight surgeon, Lieutenant Commander Joseph W. King, of Anderson, was separated from Naval service on December seventh. Doctor King was in the Navy for forty-four months, and was on duty in the Pacific area for twenty-seven months.

Major Ardis F. Melloh, of Indianapolis, has reopened his former office following his recent release from service. Major Melloh was in the Army three and one-half years. He was attached to the 104th Infantry Division, and saw eleven months of combat service in Europe.

Dr. John L. Sharp, of Crawfordsville, was recently discharged from the Army Medical Corps with the rank of major and has entered private practice. On duty with the armed forces for five years, Doctor Sharp served with emergency hospital units throughout the peak of the war on the western front following the Normandy invasion.

Recently placed on the inactive duty list by the Army, after three and one-half years' service as a medical officer, Dr. Frederick W. Buechner, of South Bend, has announced the resumption of his practice there. Major Buechner served in England and France with the Medical Corps.

Major John K. Folck, of Princeton, who served thirty-two months in the Southwest Pacific, where he was chief of surgery in a field hospital, has been released and has resumed his practice. Doctor Folck was in service a total of forty-two months, and holds the Bronze Star Medal, the Asiatic-Pacific Theatre ribbon with four battle stars, and the Philippine Liberation ribbon with one battle star.

The first North Manchester physician to go overseas, Dr. George K. Balsbaugh has announced his return to private practice there, and has taken over the offices formerly occupied by the late Dr. Ira Perry. Lieutenant Balsbaugh served with advance units all the way from the Southwest Pacific back to the Philippines during his forty-four months of service in the Army Medical Corps.

Commander Paul K. Cullen, of Indianapolis, is again practicing medicine at his former location. Commander Cullen entered service in June, 1942, and was chief of surgeons, teaching at the Great Lakes Training Center from that year to March, 1944, when he became chief of surgery of U.S.N. Pacific Hospital No. 18. He participated in the invasion of Guam, where he remained until his return.

Dr. Russell J. Baskett, of Jonesboro, has resumed his practice there, which was interrupted by his military career. Captain Baskett spent more than three and one-half years in the Army Medical Corps, with evacuation hospitals on Luzon and all over the South Pacific area, working close to the battle lines much of the time. His last station was Manila. He returned to the United States on the hospital ship *Milne* in November, and is now on terminal leave.

After forty months' military service, Dr. Joseph E. Ball, of Indianapolis, an Indiana University School of Medicine graduate with the class of 1940, has opened an office in Indianapolis. Major Ball spent thirty-two months in the Pacific theatre, as group surgeon for the Sixth Air Service Group, attached to the 13th Air Task Force. He went overseas in November, 1942, and served in New Caledonia, the Solomons, New Guinea, and the Philippines. He was placed on terminal leave in September.

Announcement has been made of the return to private practice of Dr. Robert P. Acher, formerly of Terre Haute, who has opened an office in Greensburg for the general practice of medicine. Doctor Acher, who is a 1939 graduate of Indiana University School of Medicine, enlisted in the Medical Corps of the United States Army on March 1, 1942, and was assigned to the 33rd Surgical Hospital Unit, which later became a part of the 361st Station Hospital Unit in the South Pacific theatre. This unit is now based in the Philippines. Doctor Acher, who held the rank of captain, was overseas thirty-eight months, and saw service in Australia, New Guinea, and other Army bases. Last April he was returned to the United States, when he was assigned to the Northington General Hospital, at Tuscaloosa, Alabama. He received his discharge in September.

It is always with pride that we report an award won by a Hoosier doctor: Dr. Robert W. Donnelly was accorded high honors for gallantry in action when he was given a citation following presentation of the Silver Star Medal. The citation read in part as follows: "On 20 November, 1944, following a crossing of the Meurthe River near La Voivre, France, Captain Donnelly worked for hours under enemy artillery fire, giving medical treatment to and evacuating numerous casualties. While shells burst as close as five yards from him, he moved from one wounded soldier to the next, and although two shells landed in the midst of his aid station, wounding four of his staff, he continued to supervise the evacuation of the injured." Doctor Donnelly is a 1941 graduate of the Indiana University School of Medicine, and resides in Sullivan. He returned to Sullivan after being discharged on December third.

Now on terminal leave, Dr. James S. Browning, of Indianapolis, has resumed his practice there. In the Army for more than three years, Lieutenant Colonel Browning served nineteen months in New Guinea, two months in the Philippines, and three months in Japan with General MacArthur's Army of Occupation. Colonel Browning was chief of medical service of the 161st Station Hospital.

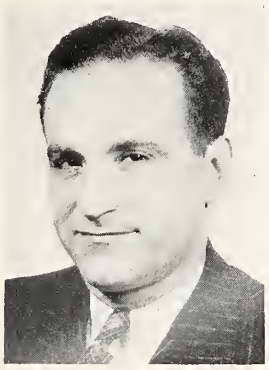
A former Decatur physician, Major Palmer Eicher, was recently placed on inactive status after three and one-half years' service, but is locating in Oklahoma City as resident orthopedic surgeon at the Bone and Joint Hospital. Doctor Eicher served in the Southwest Pacific, and upon returning to the United States spent the past two years at Fort Devens, Massachusetts, and at the Cushing General Hospital at Framingham, Massachusetts, in the Orthopedic Department.

A group of physicians from Richmond and vicinity, who have been released from service, attended a dinner in Richmond on December sixth, which was a happy sequel to a dinner held in June, 1942, just before entering active duty. Their wives were guests on both occasions. Those attending were Drs. William B. Barton, Centerville; William C. Vance, Richmond; Gayle J. Hunt, Richmond; Paul E. Dingle, Richmond; William E. Ballenger, Richmond; Russell L. Malcolm, Richmond; Charles E. Kenyon, Cambridge City; Frank H. Coble, Richmond; Paul S. Pentecost, Richmond; E. J. Meredith, Richmond; and Glen W. Lee, Richmond.

Major Bennett Kraft, of Indianapolis, has been released and has returned to his private practice. He was in the Army for thirty-eight months, thirty of which were spent overseas. Major Kraft went overseas in May, 1943, with the 58th Station Hospital, with which he served as chief of the medical service. The hospital was stationed five miles outside of Tunis, where staff members first took care of casualties of the Fortresses which were softening up Sicily; later they were in the line of evacuation for the Sicilian invasion. In January, 1944, the hospital went to Italy, about eight miles north of Naples, where it functioned as a station and air evacuation hospital until the following June when the hospital was disbanded. Major Kraft was then attached to the 17th General Hospital as chief of the Allergy Section, where he stayed until October, 1945. He considers himself very lucky in that he had the opportunity to practice medicine all the time he was in service. But the highlight of the thirty months overseas' stay must have been in May, 1945, when he was permitted to visit Bucharest, where he saw two brothers and a sister whom he had not seen for twenty-three years. He was with them on V-E Day. Doctor Kraft also had the opportunity to visit Switzerland for seven days, and highly praised the Swiss and their hospitality.

News Notes

A more effective and efficient preventable disease program in Indiana has been made possible by the organization of a new Bureau of Preventable Diseases of the Indiana State Board of Health. L. E. Burney, M.D., State Health Commissioner, has announced that George M. Brother, M.D., will be in charge of this new bureau, which will include the Divisions of Tuberculosis Control, Venereal Disease Control, Industrial Hygiene, Dental Health, Adult Hygiene and Geriatrics, and Communicable Disease Control. The grouping of these several divisions with related activities into one bureau will facilitate the co-ordination and administration of activities and result in a more effective preventable disease program.



George M. Brother, M.D.

Previous to his enlistment, Doctor Brother organized District Health Department No. 4 in the southeastern part of Indiana. Later he served as Director of the Division of Local Health Administration with the State Board of Health.

Doctor Brother, who was recently discharged, served for three years, with the rank of lieutenant colonel, as consultant in Preventive Medicine with the Fifteenth Air Force in Italy. He received the Bronze Star Award for outstanding work in malaria control.

Dr. Thomas E. Conner, of Houston, has been appointed county health officer, also jail and county farm physician, succeeding Dr. D. J. Cummings, of Brownstown, whose term expired.

Recently elected to membership in the International College of Surgeons were Drs. Hugh and Hedwig Kuhn, of Hammond, who have returned to their home after the formal induction ceremonies in Washington, D. C.

A new surgery at Billings General Hospital, built at a cost of sixty thousand dollars, has been completed and formally opened by the commanding officer. Six operations may be performed simultaneously in the modernly-equipped operating cubicles, which are provided with concentrated light, and spark-proof electric outlets are installed throughout, guarding against explosion of ether and gas. Two anesthesia rooms, and modern dressing rooms and showers for surgeons are provided. The adjoining postoperative ward is set up in three-bed sections, with nurses' stations between them.

Dr. James M. Burk, of Decatur, resigned recently as secretary of the Board of Health, at Decatur, in which capacity he had served since 1943.

Reappointment of Dr. H. S. McKee, of Greensburg, as county physician and health officer was made recently.

Dr. W. Foster Montgomery, of Indianapolis, has been appointed by Governor Gates as a member of the State Board of Beauty Culturist Examiners, to succeed the late Dr. Renos H. Richards, of Patricksburg.

Miss Elizabeth Jane Morrison, daughter of Dr. and Mrs. W. R. Morrison, of Kokomo, was married to Dr. James Franklin Land, of Youngstown, Ohio, on December twenty-ninth. Dr. Land graduated from Indiana University School of Medicine in 1945.

The Hoyt E. Dearholt Medal, of the Mississippi Valley Conference on Tuberculosis, was awarded to Mr. Murray A. Auerbach, Indianapolis, for twenty-five years service as executive secretary of the Indiana Tuberculosis Association. The presentation was made at the Chicago meeting of the conference on October ninth.

INDIANA ASSOCIATION OF THE HISTORY OF MEDICINE

A meeting of the Indiana Association of the History of Medicine was held on December 8, 1945, in connection with the Twenty-seventh Annual Conference of the Indiana History Conference, at the Smith Library, State Library and Historical Building, at Indianapolis.

This was a most interesting meeting, Mr. Howard H. Peckham, of the Historical Bureau, being the main speaker and presenting a treatise on Alexis St. Martin—Dr. William Beaumont's famous patient. He gave a complete biographical sketch of this noted man with the window in his stomach, as well as the story of the man who peered into it. Much has been said concerning Doctor Beaumont's ministration and experimentation in this case, but so far as is known this is the first article covering the patient's life history, and Mr. Peckham deserves much credit for his research concerning St. Martin and the noted experimentation which eight years later (in 1833) culminated in Doctor Beaumont's publication of *Experiments and Observations on the Gastric Juice and the Physiology of Digestion.*

Mr. Peckham's article outlined the series of exacting experiments performed by Doctor Beaumont and the difficulties he encountered in carrying out his research because of his patient's financial status and roving nature; however, his findings became a permanent contribution to medical knowledge.

A Fellow's Certificate from the American College of Surgeons, Chicago, has been received by Dr. James Y. McCullough, of New Albany.

Dr. Thomas C. Haller, of Williamsport, was recently elected a member of the International College of Surgeons. He was inducted at a meeting in Washington, D. C., on December fourteenth.

Announcement has been made by Dr. F. J. Kubik, of Westville, that he has opened an office in Michigan City. He is maintaining his office in Westville, however, and will alternate between the two locations.

Dr. Gerald Shortz, of Kendallville, has moved to Boston, where he is taking a postgraduate course in anesthesiology.

MEETING OF INDIANAPOLIS SOCIAL HYGIENE ASSOCIATION

Dr. Walter Clarke, executive director of the American Social Hygiene Association, of New York, will be the guest speaker at a luncheon meeting on Monday, February eighteenth, at the Claypool Hotel, Indianapolis. The Indianapolis Social Hygiene Association extends an invitation to members of the medical profession, and to all lay or professional persons identified with health or welfare agencies, to the ministry, and to educators. Doctor Clarke's talk will sound a call to arms to Indiana communities to continue the war on prostitution and venereal disease, and to bulwark the efforts of parents, schools, and churches in the vitally-important objective of building for sane and wholesome standards for young people. Following the luncheon, there will be a business meeting to formulate a state social hygiene council. Reservations may be made through Mrs. Meredith Nicholson, Jr., 1140 E. Market Street, Indianapolis 2.

Dr. R. W. Gehres, of Shelbyville, was recently appointed as secretary of the Board of Health, in Shelbyville.

Dr. John B. Owens, of Veedersburg, has sold his residence in Veedersburg, to move to Houston, Texas, where he will be associated with a large clinic. Dr. Owens has practiced in Veedersburg for ten years.

Returning to Clinton to resume their practice there are the Drs. C. M. and J. M. Kercheval. They have been practicing in Indianola, Mississippi, but have purchased an office site in Clinton, where they were formerly located.

The Indiana Advisory Health Council recently appointed by Governor Gates includes Dr. O. O. Alexander, Terre Haute; Dr. Harry Ross, Richmond; and Dr. Frank H. Green, Jr., Rushville. The last legislature provided for the appointment of the Council to assist the State Board of Health in the formation of policies.

Chicago Medical Society Meeting

Plans for the Clinical Conference sponsored by the Chicago Medical Society, to be held March 5, 6, 7, and 8, at the Palmer House, Chicago, are being completed. There will be scientific programs consisting of half-hour lectures beginning at 8:30 A.M. and continuing until 5:00 P.M. with intermissions for viewing the scientific and technical exhibits which promise to be outstanding. The program committee promises a discussion of the important fields of medicine by speakers from all sections of the United States. A banquet is planned for Thursday night, when a speaker of international reputation will talk on a subject of general interest. Reservations for rooms should be made through The Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2, Illinois. Make your reservation as soon as possible; hotel rooms are at a premium. Act promptly and avoid disappointment.



Major General Paul R. Hawley, war notable from College Corner, conferring with Indiana colleagues at the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, on January 13, 1946. Left to right: Dr. C. H. McCaskey, Dr. A. M. Mitchell, General Hawley, Dr. J. E. Ferrell, and Dr. C. A. Nafe.

Deaths

DIED IN MILITARY SERVICE

Colonel James W. Duckworth, M.C., of the United States Army, died on December 26, 1945, at the age of fifty-five. Colonel Duckworth was born in Gosport, in 1890, graduated from the Indiana University School of Medicine in 1912, and practiced in Indianapolis until June, 1917, when he entered the United States Army Reserve Medical Corps, later transferring to the Regular Army. He went to France with the 4th Division in May, 1918, and was returned in February, 1919, as a patient, having been gassed. Thereafter he was stationed at various posts in the United States, and served two two-year-tours of duty in the Philippines, again being assigned to the Philippines in 1940.



Colonel James W. Duckworth

In May, 1941, Colonel Duckworth was commanding officer of the hospital at Fort William McKinley, in Manila, and commanded the Twelfth Medical Regiment. At the time the war broke out all available doctors were sent into Manila to establish a hospital center, and there he became the executive officer of the Manila Hospital Center. This assignment lasted only ten days, during which time about seven large hospitals were set up, but these hospitals were never used by the Americans inasmuch as they were all ordered to Bataan and Corregidor. Colonel Duckworth went to Bataan on December 25, 1941, and there he established General Hospital No. 1, which was bombed several times. The hospital unit surrendered on April 9, 1942, but Colonel Duckworth was allowed to remain as commanding officer of the hospital until July second, when all patients were evacuated to Manila and sent to Camp O'Donnell as a unit. There he established five one-thousand-bed hospitals—another hospital center.

Colonel Duckworth has been given credit for reducing the death rate of the Filipino prisoners from two hundred a day to one a day in two months' time. He was transferred to various prison camps, and on January 31, 1945, was released from Camp Cabanatuan by the Rangers of the Sixth Army. He was returned to the United States by plane, and entered the Letterman General Hospital, in San Francisco, as a patient. On May 27, 1945, he returned to duty at his own request after only a seven-day leave, and was assigned as commanding officer of the Winter General Hospital, at Topeka, Kansas. After V-J Day plans were made to close the Winter General Hospital, and he was then placed in command of the Lawson General Hospital, at Atlanta, Georgia, where he was stricken with a cardiac condition Christmas night and died December 26, 1945.

Colonel Duckworth was a member of the American College of Surgeons, the Indianapolis (Marion County) Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.



Herman G. Morgan, M.D.

Herman G. Morgan, M.D., of Indianapolis, died on January eighth, at the age of sixty. Following his graduation from the Indiana University School of Medicine, in 1909, Doctor Morgan practiced for a year and a half in Colorado, and then returned to Indiana, where he became secretary of the Indianapolis Board of Health, a position he held and filled very capably for thirty-three years.

Doctor Morgan was instrumental in enacting the pasteurization law, and in such public health improvements as the establishment of tuberculosis clinics, school nurseries, typhoid and smallpox inoculations in public schools, infant feeding clinics, and the Venereal Disease Control Program established during World War II, which has been considered as a model for other cities.

For his unending efforts, Doctor Morgan has received many honors, the last being conferred when the new health center of Flanner House, negro welfare agency, was dedicated as the Herman G. Morgan Health Center.

During World War I, Doctor Morgan assisted in the organization of the Lilly Base Hospital No. 32. He was stationed at Fort Harrison as a member of the United States Public Health Service, although he still carried on his duties with the

Board of Health. He was also superintendent of the Indianapolis City Hospital in 1918 and 1919, and an instructor of public health and sanitation at the City Hospital School of Nursing, a position he filled until a short time before his death.

Doctor Morgan was a member and past president of the Indianapolis (Marion County) Medical Society, a member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

James G. Bostwick, M.D., of Mishawaka, died January seventh, after an illness of six months. He was sixty-seven years of age, and was a graduate of the Rush Medical College, in Chicago, in 1902. He had practiced for forty-three years, specializing in otolaryngology. He was a member of the St. Joseph County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

William M. Bigger, M.D., of Hammond, died December thirtieth, after an illness of three years. He was seventy-four years of age, and was a graduate of the University of Pittsburgh School of Medicine, Pittsburgh, in 1897. During World War I he served as a captain in the Army Medical Corps. He was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Walter McDowell, M.D., of Evansville, died suddenly in his office November twenty-seventh, at the age of forty. He had been a Lieutenant in the Army Medical Corps, having served at the Army-Navy Hospital at Hot Springs, Arkansas, and at Camp Rucker, Alabama, until his discharge. Doctor McDowell was a graduate of Indiana University School of Medicine in 1929, and had specialized in pediatrics. He was a member of the Vanderburg County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Clarke Rogers, M.D., of Indianapolis, died suddenly while leaving his office on December twenty-first, at the age of sixty-eight. Doctor Rogers was a member of the Indianapolis Board of Public Health in 1944, and had previously served on the health board from 1933 through 1936. He was also on the City Merit Commission from 1941 until 1944, and was a trustee of the State Soldiers' Home from 1920 until 1933. He served as a captain in the Medical Corps during World War I. He was a graduate of the Medical College of Indiana, Indianapolis, in 1899, and was a member of the Indianapolis Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

John P. Pennell, M.D., of Kokomo, died on October nineteenth of a malady which overtook him while he was serving in the armed forces. Doctor Pennell was a graduate of the Indiana University School of Medicine, in 1935. He was thirty-four years of age. He practiced in Kokomo until January 5, 1941, when he was called into service.



John P. Pennell, M.D.

Doctor Pennell was the first doctor to go into service from Kokomo. He was at Fort Benning, Georgia, and Camp Blanding, Florida, until March of 1942, at which time he was sent to Canada, to Fort St. John in British Columbia. There a field hospital was erected to care for the engineers who were building the Alcan Highway, and it was there Doctor Pennell became ill, and was sent back to the United States in January, 1943.

He was then stationed at Camp Reynolds, Pennsylvania, until December, going from there to Trinidad, where he remained until March, 1944. Immediately after being given a medical discharge in October, 1944, at which time he was a captain, he returned to Kokomo and resumed practice. He died in a Columbus, Ohio, hospital.

Doctor Pennell was a member of the Howard County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Ira E. Bowman, of Odon, died December thirtieth at the Daviess County Hospital, in Washington, at the age of sixty-four. He was a graduate of the Indiana University School of Medicine, Indianapolis, in 1910, and was a member of the Daviess-Martin Medical Society, the Indiana State Medical Association, and the American Medical Association.

Charles G. Dick, M.D., retired physician of Elwood, died November twenty-fifth at the home of his son in Indianapolis, at the age of seventy-nine. He was a graduate of the Keokuk Medical College, of Keokuk, Iowa, in 1895, and was a member of the Madison County Medical Society, the Indiana State Medical Association, and the American Medical Association.

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Society Reports

LOCAL SOCIETY REPORTS

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Lawrence County

Washington County

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Vice-President, Richard K. Schmitt, Columbus.
Secretary-Treasurer, Byron K. Zaring, Columbus.

CASS COUNTY MEDICAL SOCIETY
President, John C. Davis, Logansport.
Vice-President, Paul H. Wilson, Logansport.
Secretary-Treasurer, Brice E. Fitzgerald, Logansport.

DELAWARE-BLACKFORD COUNTY MEDICAL SOCIETY
President, Elmer T. Cure, Muncie.
President-Elect, Thomas R. Owens, Muncie.
Secretary, Bruce W. Stocking, Muncie.
Treasurer, W. J. Molloy, Muncie.

DUBOIS COUNTY MEDICAL SOCIETY
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Vice-President, Henry G. Backer, Ferdinand.
Secretary-Treasurer, Paul J. Blessinger, Jasper.

FAYETTE-FRANKLIN COUNTY MEDICAL SOCIETY
President, George N. Love, Connersville.
Vice-President, C. L. Entner, Connersville.
Secretary-Treasurer, R. H. Elliott, Connersville.

FLOYD COUNTY MEDICAL SOCIETY
President, Martin B. Strange, New Albany.
Vice-President, Thomas Hewlett, New Albany.
Secretary-Treasurer, Phillip Cohn, New Albany.

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President, Frank A. Van Sandt, Bloomfield.
Vice-President, William F. Craft, Linton.
Secretary-Treasurer, George E. Moses, Worthington.

JACKSON COUNTY MEDICAL SOCIETY
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Vice-President, D. J. Cummings, Brownstown.
Secretary-Treasurer, G. H. Kamman, Seymour.

JASPER-NEWTON COUNTY MEDICAL SOCIETY
President, R. H. Ruhmkorff, Goodland.
Secretary-Treasurer, W. G. Pippenger, Brook.

JAY COUNTY MEDICAL SOCIETY
President, F. E. Keeling, Portland.
Vice-President, John Lansford, Red Key.
Secretary-Treasurer, H. Frederick Streib, Portland.

JENNINGS COUNTY MEDICAL SOCIETY
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Vice-President, W. L. Gossman, North Vernon.
Secretary-Treasurer, John H. Green, North Vernon.

KNOX COUNTY MEDICAL SOCIETY
President, William Schulze, Vincennes.
Vice-President, Maurice S. Fox, Vincennes.
Secretary-Treasurer, C. L. Boyd, Vincennes.

MARSHALL COUNTY MEDICAL SOCIETY
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Vice-President, C. R. Graham, Bourbon.
Secretary-Treasurer, L. W. Vore, Plymouth.

MONTGOMERY COUNTY MEDICAL SOCIETY
President, John L. Sharp, Crawfordsville.
Vice-President, J. M Kirtley, Crawfordsville.
Secretary-Treasurer, Wemple Dodds, Crawfordsville.

MORGAN COUNTY MEDICAL SOCIETY.
President, H. H. Dutton, Martinsville.
Secretary-Treasurer, Robert W. Van Bokkelen, Mooresville.

RANDOLPH COUNTY MEDICAL SOCIETY
President, Lowell W. Painter, Winchester.
Vice-President, Robert W. Reid, Union City.
Secretary-Treasurer, Wayne Harmon, Lynn.

RIPLEY COUNTY MEDICAL SOCIETY
President, Noel D. Moran, Versailles.
Secretary-Treasurer, R. Lee Smith, Osgood.

SHELBY COUNTY MEDICAL SOCIETY
President, John A. Davis, Flat Rock.
Vice-President, R. M. Nigh, Fairland.
Secretary-Treasurer, D. B. Silbert, Shelbyville.

STEUBEN COUNTY MEDICAL SOCIETY
President, B. A. Blosser, Fremont.
Vice-President, G. N. Lake, Pleasant Lake.
Secretary-Treasurer, Donald Creel, Angola.

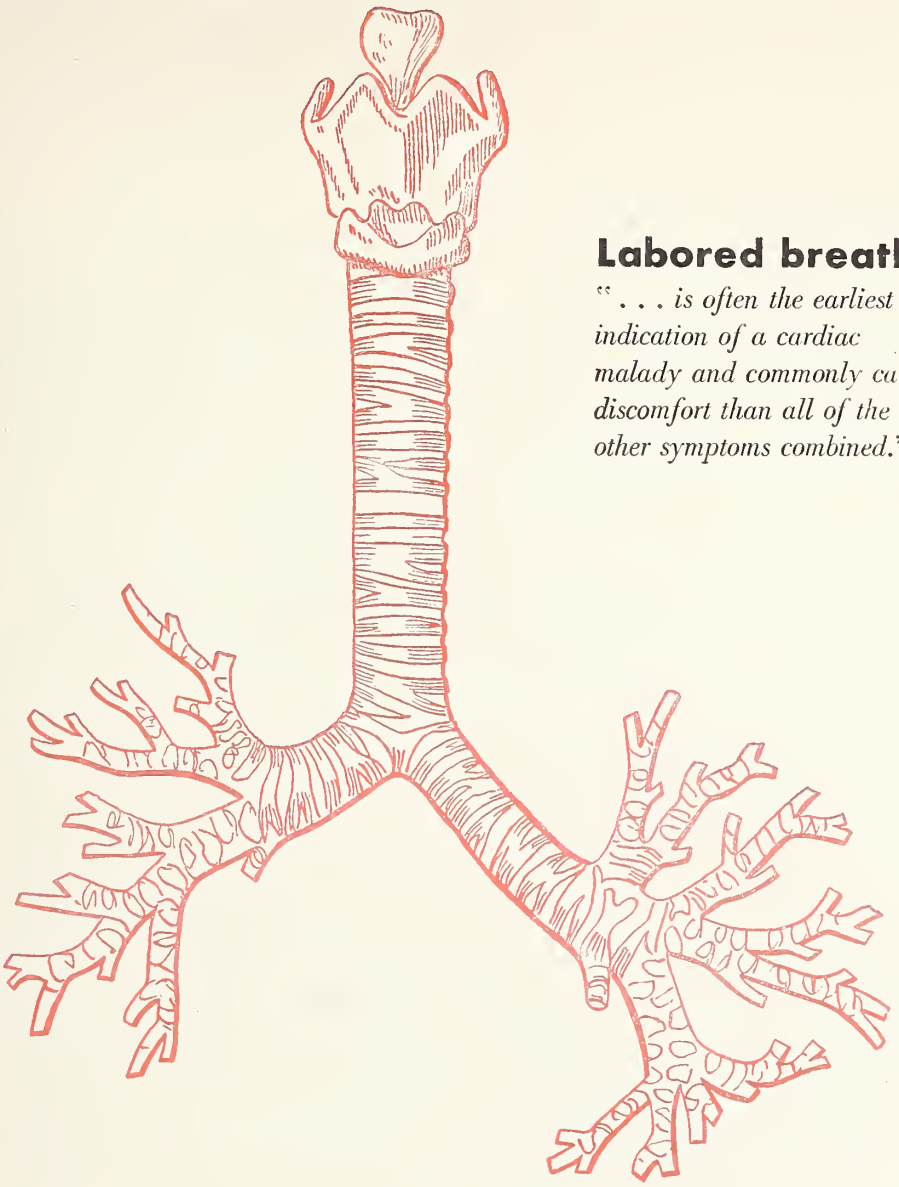
TIPTON COUNTY MEDICAL SOCIETY
President, A. E. Stouder, Kempton.
Vice-President, H. L. Ericson, Windfall.
Secretary-Treasurer, W. A. Kurtz, Windfall.

WHITLEY COUNTY MEDICAL SOCIETY
President, Benjamin F. Pence, Columbia City.
Vice-President, Arthur Leiter, Columbia City.
Secretary-Treasurer, Otto F. Lehmberg, Columbia City.

Delaware-Blackford County Medical Society members met at Hotel Roberts, in Muncie, on December eighteenth, for their regular business meeting and annual election of officers. Twenty-six members were present.

Another meeting was held on January fifteenth at Hotel Roberts, Muncie. The guest speaker was Dr. Robert Butterfield, of Muncie, whose subject was "Scrub Typhus." Twenty-seven members were present.

Fort Wayne (Allen County) Medical Society members met at the St. Joseph Hospital Nurses' Home, in Fort Wayne, on December thirteenth. Colonel Truman G. Blocker, of the Plastic Surgery Department, and Captain Weiss, of the Oral Surgery Department, of Camp Atterbury, spoke on "Maxillofacial Plastic Surgery." Their talks were illustrated with lantern slides and plaster molds. Approximately one hundred members and guests were present.



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1. Harrison, T. R.: Cardiac Dyspnea, Western J. Surg., 52:407 (Oct.) 1944.

SEARLE *Research in the Service of Medicine*

DeKalb County Medical Society members held a meeting on December twenty-first, at the Auburn Hotel, at Auburn. Officers were elected for 1946. Thirteen members attended the meeting.

Fayette-Franklin County Medical Society members met at the McFarlan Hotel, in Connersville, on December eleventh. Eleven members were present.

Greene County Medical Society members held a meeting, on December twenty-eighth, at the Freeman Greene County Hospital, at Linton. An election of officers was held, in addition to the regular business session. Ten members attended the meeting.

At another meeting on January seventeenth, the Greene County Medical Society members met at the Freeman Greene County Hospital, at Linton, for a business session and general discussion. Thirteen members were present.

Howard County Medical Society members met at the Frances Hotel, at Kokomo, on January fourth. The guest speaker was Dr. Kenneth G. Kohlstaedt, of Indianapolis, who discussed "Recent Therapeutic Advances." Twenty-eight members were present.

Indianapolis (Marion County) Medical Society members held a meeting at the White Cross Service Center, of the Methodist Hospital, at Indianapolis, on January fifteenth. Case reports were presented by Dr. Don E. Wood, Dr. William M. Dugan, Dr. Paul J. Fouts, and Dr. Charles F. Thompson, all of Indianapolis.

On January twenty-second another meeting was held at the White Cross Service Center, when Dr. Richard H. Lyons, of the University of Michigan, presented a paper on "General Principles in the Management of Edema."

At their meeting on January twenty-ninth, Dr. John A. Campbell, of Indianapolis, discussed "Survey Film Diagnosis of Abdominal Conditions," and Dr. Earl W. Mericle, of Indianapolis, spoke on "Front Line Psychiatry."

Knox County Medical Society members met on December eighteenth, at the Grand Hotel, at Vincennes. Dr. R. C. Meyer, of Vincennes, presented a paper on "Pulmonary Tuberculosis." Seventeen members attended the meeting.

Lake County Medical Society members met at Peter Levent's Restaurant, in Hammond, on January tenth. Guest speaker was Dr. L. E. Burney, of Indianapolis, whose subject was "What About Public Health?" Ninety members were present.

Lawrence County Medical Society members held a meeting on December fifth, at the Dunn Memorial Hospital, at Bedford, when the annual election of officers was held. Members voted to hold tuberculosis clinics in Bedford this year.

Miami County Medical Society members met at Peru on December twenty-eighth. In addition to the regular business meeting, election of officers for 1946 was held. Ten members were present.

Montgomery County Medical Society members held a meeting, on December twentieth, at the Culver Hospital, at Crawfordsville. A colored motion picture with sound track, by Dr. J. E. F. Riseman, of Boston, on "Angina Pectoris," was presented. Twenty-one members were in attendance at this meeting.

Monroe County Medical Society members elected officers at a meeting in Bloomington on November twenty-eighth, and heard a report on the French Lick session, with particular reference to the prepayment medical care plan. Twenty-two doctors attended the meeting.

Morgan County Medical Society members held their annual Christmas dinner meeting on December nineteenth, at the Morgan County Memorial Hospital, at Martinsville. Eight members were present.

Noble County Medical Society members met at Kendallville on December eighteenth. Dr. John W. Morr, of Albion, presented a paper on "Medical Ethics," and a moving picture by Bauer and Black, on "Traumatic Injuries," was shown. Twelve members attended the meeting.

Porter County Medical Society members met at the Porter Memorial Hospital, at Valparaiso, on December eighteenth. Officers were elected for 1946.

Randolph County Medical Society members met at the Elks Club, at Union City, on December nineteenth. Election of officers followed their annual banquet. Eleven members were present.

Shelby County Medical Society members held a dinner meeting, on January ninth, at Shelbyville, for returning medical officers from that county. It was a social meeting and the wives were invited. The society is placing a Bronze Plaque in the Major Hospital, at Shelbyville, with the names of the Shelby County physicians who were in service.

Vanderburgh County Medical Society members held a meeting at Hotel McCurdy, at Evansville, on December eleventh, when an election of officers was held. The principal speaker was Dr. Marion F. Beard, of Louisville, who spoke on "Anemia."

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- To attend a banquet on Thursday night

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Registration Fee, $5.00

Wabash County Medical Society members met on December fifth, at Hotel Indiana, at Wabash. Annual election of officers was held. Dr. L. P. Harshman, of Fort Wayne, was the principal speaker. Fifteen members and several guests were present, the Wabash County Nurses' Association having been invited as special guests at this meeting.

Warrick County Medical Society members met on January eighth at the Court House, in Boonville, when an election of officers for 1946 was held. Five members were present.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. F. M. Gastineau, Indianapolis
President-elect—Mrs. S. J. Petronella, East Chicago
Corresponding Secretary—Mrs. C. L. Bock, Indianapolis
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis
Secretary—Mrs. Leon L. Blum, Terre Haute

NOTICE!

The House of Delegates to the Woman's Auxiliary to the Indiana State Medical Association will convene on Thursday, April twenty-fifth, at the Columbia Club, in Indianapolis. Watch for further information regarding this meeting.

Mrs. F. M. Gastineau, our state president, will soon be sending all county presidents and standing committee members important information concerning the Wagner-Murray-Dingell and Pepper bills. These kits are to be saved and studied for future reference. All the latest information on current medical legislation and the recommendations of the American Medical Association will be contained in this kit. The American Medical Association has asked the co-operation of the auxiliary in this matter.

Following is a resolution that was passed at the House of Delegates of the American Medical Association on December fifth:

"WHEREAS, The object of the Woman's Auxiliary is to aid the American Medical Association in every way requested; and

"WHEREAS, The most urgent need at the present time is for widespread dissemination of knowledge concerning the hazards of current medical legislation; Therefore be it

RESOLVED, That the House of Delegates of the American Medical Association requests the Woman's Auxiliary to use every avenue possible to bring such information to its members, and through them to the public."

The above resolution was presented by Dr. Francis F. Borzell, of Philadelphia, Pennsylvania.

COUNTY REPORTS

ALLEN

Mrs. S. R. Mercer entertained the Allen County Auxiliary at her home on December eleventh. This was the annual Christmas party of the group.

LAKE

The Hammond Branch of the Lake County Auxiliary held a white elephant sale at the St. Margaret Hospital Nurses' Home, on December eleventh. Members of the Gary and East Chicago branches were guests.

MADISON

The December meeting of the Madison County Auxiliary was held on December seventeenth. Following a five o'clock dinner at a restaurant the group held a Christmas party at the home of Mrs. Rex Dixon. Gifts for children at St. John's Hospital were collected, and members exchanged gifts. Following a brief business session bridge was played.

VANDERBURGH

A membership tea was held by the Vanderburgh Auxiliary on December eleventh at the home of Mrs. William F. Healy.

HOWARD

Mrs. F. M. Gastineau spoke at a meeting of the Howard County group, in Kokomo, on January fourth. Dinner was served at a hotel, after which the members proceeded to the home of Mrs. Paul Perry. Mrs. R. P. Schuler presided at the business meeting. Mrs. Gastineau reported on her recent trip to Chicago, where she attended the Presidents' Conference. About fifty people were there, and a great many of the states sent representatives. She told of their discussion of current national legislation pertaining to medicine, and explained the fourteen-point program.

MARION

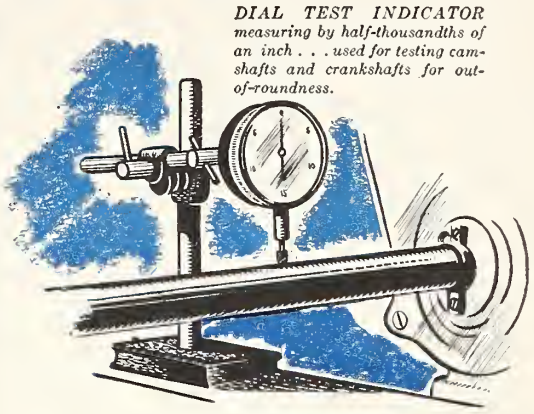
On January fourteenth the Auxiliary to the Indianapolis Medical Society held its annual legislative meeting at the St. Vincent Hospital Nurses' Home. Dr. Leroy Burney spoke on "New Developments in Public Health Service in Indiana." Doctor Burney is health commissioner of Indiana. Following the business meeting tea was served.

NON-BATTLE FATIGUE

A war hero someone was telling us about had the darndest time getting into battle. Seems he broke his glasses just before a fight and was sent off to Manila General Hospital for a new pair. At the eye clinic they discovered he had sinus trouble. He was operated on for that. Recuperating, he developed a skin rash. The medics administered penicillin and while under treatment he had to stop taking atabrine. So he came down with malaria.

Recovered finally, and ready to return to the fray, he was told to stop at the eye clinic to pick up his new glasses. Our hero weighed the chances, decided the battlefield was safer and went off to hunt Japs, leaving the glasses behind.

—*Pageant.*



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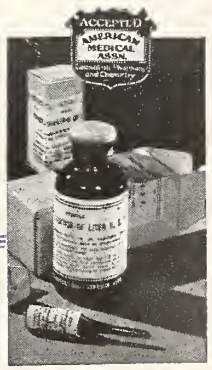
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INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT—NOVEMBER, 1945

Diseases	*Nov. 1945*	*Oct. 1945*	*Sept. 1945*	*Nov. 1944*	*Nov. 1943*
Chicken Pox	159	82	34	278	314
Measles	18	17	16	19	407
Scarlet Fever	260	217	87	266	265
Smallpox	4	1	0	3	9
Typhoid Fever	7	6	17	6	2
Paratyphoid Fever	1	0	1	0	0
Whooping Cough	105	113	87	44	111
Diphtheria	62	55	31	32	67
Influenza	410	26	12	19	65
Pneumonia	9	11	7	4	26
Mumps	47	22	30	56	115
Poliomyelitis	13	36	77	15	2
Cerebro-Spinal Meningitis	12	8	13	14	13
Meningitis, Nonepidemic	2	2	0	4	0
Undulant Fever	4	4	6	7	5
Tetanus	3	1	3	0	0
Vincent's Angina	2	1	3	0	1
Tularemia	2	0	0	1	2
Septic Sore Throat	13	13	0	0	0
Food Poisoning	1	0	1	0	0
Malaria—Acquired Outside United States	10	11	8	1*	3*
Infectious Jaundice	4	1	2	0	0
Erysipelas	4	0	3	0	1
Impetigo	13	1	2	2	0
Encephalitis	2	3	6	1	2
Rubella	1	5	0	2	8
Dysentery	1	14	15	0	0
Rabies in Man	1	0	1	0	0
Tuberculosis, Pulmonary	285	135	177	264	128
Tuberculosis, Other Forms	23	3	6	9	40

* Not stated as to whether the case acquired infection outside or inside the United States.

RADIO CALENDAR

"YOUR HEALTH IN WARTIME"

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Indiana State Medical Association — "Ladies, Your Health!"—Monday, 2:45 P.M., WFBM, Indianapolis

Vigo County Medical Society — Thursday, 12:15 P.M., WBOW, Terre Haute.

St. Joseph County Medical Society — Friday, 1:45 P.M., WSBT, South Bend.

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BOECK'S SARCOID*

MORTIMER MANN, M.D.

MAX D. BARTLEY, M.D.

JOSEPH E. DUKES, M.D.

INDIANAPOLIS

Boeck's sarcoid is an uncommon disease which is interesting to all fields of medicine because of its protean manifestations. The skin changes were first described by Boeck[1] (1899), who called the lesions sarcoid because he thought they resembled sarcoma. The modern concept of the disease was defined by Schaumann[2] (1916), who described the condition as a relatively benign chronic granulomatous disorder which was capable of affecting any organ of the body with a predilection for the reticulo-endothelial system.

SYMPTOMATOLOGY

Sarcoidosis is a chronic disease of unknown etiology lasting for many years, but usually ending in complete recovery. It occurs most frequently between the ages of twenty and thirty years, and is more common in negroes. The patients often complain of fatigue and dyspnea, but do not appear emaciated or toxic. Lymphadenopathy is present in some stage of the disease in 90 per cent of the cases. The nodes are painless, discrete, movable, and firm. They may undergo spontaneous regression. Splenomegaly is another common finding. Cutaneous lesions have been noted in about 50 per cent of the cases, and may appear in many different forms. The usual lesion is characterized by the appearance of sharply-defined, brownish, cutaneous or subcutaneous nodules which are distributed over the face, but may also be found on the extremities. Pulmonary involvement is also frequently observed, and may cause dyspnea. Roentgen findings reveal a diffuse nodular mottling throughout the lung fields simulating tuberculosis; however, the lesions in sarcoid are usually larger and less uniform in distribution.

Ocular involvement occurs in about 50 per cent of the cases, and any structure of the eye may be affected. The most common finding is a chronic, bilateral, granulomatous iritis which does not produce much redness or pain. Heavy lardaceous deposits appear on the posterior surface of the cornea. The iris may become vascularized, and nodules are usually present on the pupillary border. The iritis runs a long course, but tends to regress and heal with a minimum of permanent damage. In some cases the process is more destructive, and the eye goes on to phthisis bulbi. When iritis is associated with parotitis and fever a syndrome is present which was originally described by Heerfordt. Recent clinical and pathological studies of this syndrome would indicate that it is another phase of sarcoidosis.[3] Mikulicz's syndrome may occur when the lacrimal and salivary glands become involved.[4]

In 15 per cent of the cases changes are observed in the small bones of the hands and feet. Roentgen

* From the Departments of Ophthalmology and Medicine, Indianapolis City Hospital, Indianapolis, Indiana.

[1] Boeck, C.: Multiple Benign Sarkoid of Skin. *J. Cutan. and Genito-Urin. Dis.*, **17**:543, 1899.

[2] Schaumann, J.: *Etude sur le lupus pernio et ses rapports avec les sarcoides et la tuberculose, Ann. de dermat. et syph.*, **6**:357, 1916.

[3] Hamburger, L. P., and Schafer, A. J.: Uveoparotid Fever as a Manifestation of Mikulicz's Syndrome, *Am. J. Dis. Child.*, **36**:434, (September) 1928.

[4] Scott, R. B.: Sarcoidosis of Boeck, *Brit. M. J.*, **2**:777, (Oct. 15) 1938.

examination shows areas of rarefaction surrounded by a zone of increased density.

LABORATORY FINDINGS

Hematological studies may reveal a microcytic hypochromic anemia. The white blood count is normal with no change in the differential except for an occasional eosinophilia. The total blood proteins are normal, but there is a tendency toward reversal of the albumin-globulin ratio due to an elevation of the serum globulin. Blood calcium may be slightly elevated. The sedimentation rate is often increased. There is usually an anergy to tuberculin.

The diagnosis of Boeck's sarcoid is made by demonstrating characteristic lesions in a skin nodule or suspicious lymph node. These changes consist of a proliferation of histiocytes to form discrete collections of epitheliod cells among which occasional giant cells are seen. The giant cells contain peculiar, heavily hematoxylin-staining inclusion bodies first described by Schaumann. The changes differ from the lesions observed in tuberculosis in that there is no surrounding lymphocytic infiltration, no caseation, and tubercle bacilli have never been observed.[5] It should be emphasized that the pathologic changes are spotty in distribution so that any combination of clinical findings may occur.

CASE REPORT

R. A., a married, colored female, aged twenty-six, was admitted to Sunnyside Sanatorium on March 28, 1945. About four weeks prior to admission she noticed loss of weight, fatigue, and shortness of breath on exertion. A physician was consulted who took an x-ray and told her she had tuberculosis. She had a slight cough, and brought up sputum with difficulty. There was no hemoptysis, chest pain, night sweats, or chills. Her appetite was good although her weight had fallen from one hundred fifteen to ninety-eight pounds. She suffered from frequent colds, but had never had any serious illness. The patient had five pregnancies, two of which terminated in a miscarriage. Three were carried to full term, and the children are living and well. Family history was negative for tuberculosis.

The only positive finding on physical examination was a poorly-nourished, colored female. Laboratory data obtained from Sunnyside showed the following: Sputum examinations by direct smears, cultures, and guinea pig inoculations were negative. Gastric washings also failed to reveal the presence of tubercle bacilli. Tuberculin patch test was negative. A Mazzini test was negative. Agglutinations were negative for typhoid and brucellosis. Total protein was 7.3 gm. per cent, albumin 4.32 gms. per cent, and globulin 2.98 gm. per cent. Sedimentation rates were normal. Blood count was



Figure I.
Pulmonary involvement due to sarcoidosis.

normal, and urine was negative. Stereoscopic films of the chest were taken, and read as follows: "Bony thorax normal; diaphragmatic shadows normal. The heart shows a slight prominence in the left auricular area, but is believed to be within the limits of normal; the heart is otherwise normal. The lung fields show a bilateral symmetrical, lace-like density. There are several densities in the hilar area on both sides. The interlobar septum on the right is thickened (Fig. I). Conclusions: bilateral, symmetrical density throughout the lung fields, the nature of which is not known. Atypical pneumonia and tuberculosis and pneumoconiosis must be ruled out."

The patient was afebrile during her hospital stay and had no complaints until four months after admission when she noticed blurred vision in the right eye. Two weeks later the vision in the left eye became blurred. On examination there was no ciliary or conjunctival congestion. The corneas appeared hazy and deposits were grossly visible on the posterior surface. On the pupillary border of each iris several grayish nodules could be seen. The fundi did not show any abnormalities. The appearance of a nodular iritis in a patient with a lung lesion which was probably not tuberculosis suggested a diagnosis of Boeck's sarcoid. The patient was discharged from Sunnyside with a recommendation that she be followed at the Indianapolis City Hospital.

The patient was admitted to the City Hospital in August, 1945, and her complaints were the same as previously described. In addition, she had developed pain in her chest, and vision was still blurred. Physical examination was negative except for the eye findings, and small, discrete, movable lymph nodes in the supraclavicular region. A more detailed ocular examination was made with a slit lamp, and the same findings were noted in each eye. Heavy lardaceous deposits were present on the posterior surface of the cornea. A faint ray could be seen in the anterior chamber. The iris was fully dilated by atropine. There were many small nodules on the pupillary border. Pigment deposits were present on the lens capsule where synechiae had formed. The fundi were negative. Tension was normal. X-ray of the chest showed no change from the previous findings. There was no x-ray evidence of any bony involvement of the hands or feet. Bronchoscopy did not reveal any abnormalities. Cultures taken from the bronchi

[5] Woods, A. C., and Guyton, J. S.: Role of Sarcoidosis and of Brucellosis in Uveitis, *Arch. of Oph.*, 31:469, 1945.

were negative. Mantoux test was negative to a concentration of 0.1 mg. Her temperature remained normal. All laboratory procedures mentioned were repeated, and the following changes noted: Sedimentation rate, by the Wintrobe method, was increased to 42 mm. in sixty minutes. There was also an elevation in the globulin fraction of the serum protein to 3.3 gm. per cent. Total protein was 6.8 gm. per cent. Blood calcium was 9.6 mg. per cent. One of the enlarged supraclavicular lymph nodes was excised for biopsy. The histopathologic report was as follows: "Sections reveal nodules dispersed in a background of lymphoid stroma. The nodules are roughly the size of miliary tubercles, or are smaller. They consist of aggregations of epithelioid cells. The latter have abundant eosinophilic cytoplasm. There is a suggestion of radial disposition of these cells in the nodules, but, by and large, there is no striking degree of polarity. Foreign body giant cells are rare, and caseation is entirely absent. Delicate collagen fibrils lie between the cells and about the nodules. Occasionally round, ovoid or bean- or clover-shaped bodies a little larger than epithelioid cells are seen in the cell clusters. These stain a dark purplish-blue, and have the appearance of inclusion bodies usually seen in sarcoid. About and between the tubercle-like nodules, lymphocytes and histiocytes are scattered evenly and in abundance, making up the aforementioned stromal background (Fig. II).

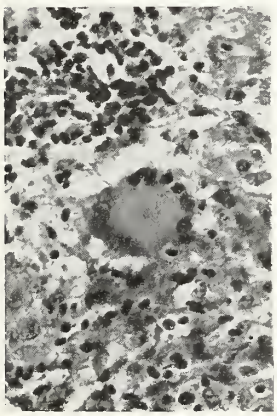


Figure II.
Lymph node showing histopathologic changes found in Boeck's sarcoid.

The patient was discharged from the hospital and has resumed her household duties. A recent examination did not show any notable change in her eyes, and there has been no resolution of the lung lesions.

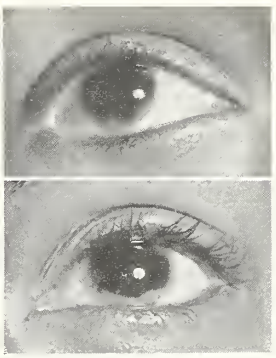


Figure III.
Bilateral iritis with heavy, lardaceous deposits on lower peripheral portion of each cornea. Right cornea is more hazy because of elevated intra-ocular pressure. Nodules can be seen on pupillary border of left eye.

Since submitting the report on the above case, another colored female, twenty-four years old, with Boeck's sarcoid has been observed. This patient was still more interesting since she also had a carcinoma of the breast. She was first seen in 1943 because of blurred vision in both eyes. Examination showed a plastic iritis with heavy lardaceous deposits on the posterior surface of each cornea (Fig. III). Nodules were present on the pupillary border of the iris. Physical examination revealed enlarged arterior cervical lymph glands and a palpable spleen. An x-ray of the chest showed a mass in both hilar regions. Roentgen examination of hands and feet were negative. A 2 per cent eosinophilia was found on repeated blood counts. Hemoglobin, red cell count, and sedimation rate were normal. Total blood proteins were increased to 8.3 gms. per cent, the albumin fraction being 5.1 gms. per cent, and the globulin 3.2 gms. per cent. Mantoux reaction was positive to 0.1 mg. of old tuberculin. A tentative diagnosis of Boeck's sarcoid was considered, but the patient moved away before a biopsy could be obtained. She returned two years later. Examination did not reveal any change in the appearance of her eyes. However, a secondary glaucoma was now present in the right eye. There was also a tumor mass about the size of a walnut in the right breast. Roentgen examination of the chest showed a complete disappearance of the mass which was previously observed in each hilar region. The tendency for lesions to spontaneously resolve is typical of sarcoidosis.

The patient was referred to the surgical service and a biopsy was taken from the breast tumor, which proved to be carcinoma. A radical mastectomy was done, removing a solitary lymph gland from the axilla. Further histologic study of the tumor revealed it to be a scirrhous carcinoma. The lymph gland which was first thought to contain a metastatic lesion showed the characteristic changes of Boeck's sarcoid.

THE SOUL OF ENJOYMENT

Health is the soul that animates all enjoyments of life, which fade and are tasteless, if not dead, without it.—*Sir William Temple.*

ENDOCRINOLOGY IN OFFICE PRACTICE*

JAMES H. HUTTON, M.D.

CHICAGO

Even in normal times it is probable that the majority of our patients were ambulatory and came to the office for diagnosis and treatment. The present shortage of doctors and hospital beds has increased this percentage. Before the war difficult cases could be sent to laboratories or hospitals for more complete study. Nowadays that is difficult and in many cases practically impossible; consequently, physicians have to depend more on a diagnosis arrived at by the use of their five senses without recourse to laboratory or hospital facilities than at any other time in the past quarter century.

Most endocrinopathies occur in ambulatory patients. They are as easily recognized as is the nature of many of the complaints of ambulatory patients, and as satisfactorily treated. This is not true of such conditions as Addison's disease, Cushing's syndrome, hyperparathyroidism, and other difficult problems of that kind. Such syndromes are comparatively rare—Illinois has a population of about 7,000,000, with only twenty-five deaths from Addison's disease each year. The most important, because they are most numerous, are the milder forms of endocrine disorders, such as hypothyroidism, pituitary deficiency, Fröhlich's syndrome, and menstrual disorders. My remarks will have to do with the diagnosis and treatment of the milder forms of endocrinopathies.

It is hoped that the suggestions offered will save you some time and trouble and enable you to arrive at a reasonably accurate diagnosis and control treatment without some of the laboratory data you would ordinarily secure. If a diagnosis cannot be made and correct treatment instituted, at least the direction of further study will be indicated by a careful history, some of the significant points of which will be pointed out—the physical findings and a few therapeutic tests.

First, the patient should be considered as an entity instead of centering attention on some one organ or some phase of the complaints or laboratory findings. Some years ago Frank[1] showed that amenorrhea occurred in the absence of estrogen in the blood or urine, and also when normal or supernormal amounts were present. Better results were obtained when the patient was considered as an individual and all abnormalities such as obesity, vitamin deficiencies, et cetera, were corrected. Within the last few years I have seen three patients who illustrated the fact that a patient may have an endocrine disorder in addition to some other syndrome.

The first case was a woman referred to me by the late Dr. Philip H. Kreuscher. Her complaints were those of backache, obesity, fatigue, headache, and other symptoms of hypopituitarism and hypothyroidism. Dr. Kreuscher was the third orthopedic surgeon whom she had consulted about the backache. A diagnosis of rupture or slipping of an intervertebral disc had been made. Operation had been advised. Her obesity was of the pituitary-thyroid deficiency type, and treatment for its correction was undertaken. There was no thought on my part that the endocrine disorders had more than a coincident relationship to the chief complaint. To my surprise her reduction in weight and correction of other thyroid and pituitary symptoms was accompanied by complete disappearance of the backache, which has never recurred although the weight has been regained.

The second case was a teacher who complained of low-back pain radiating down the back of both thighs. This was so severe that she had difficulty in doing her work. She was also a victim of pituitary-thyroid dyscrasia, and treatment thereof, which was accompanied by loss of weight, was also followed by complete disappearance of her back symptoms.

The third case complained of pain in the left hip and inability to straighten the left leg when lying down. This had persisted following a fracture of the pelvis sustained seven years before. She had been studied in a teaching hospital and had been told that her injury was responsible, and that she would have to learn to live with her disability. However, she also complained of exhaustion, diurnal somnolence, paroxysmal tachycardia, symptoms of pituitary and thyroid dyscrasia, and menopausal symptoms. The other disability disappeared coincident with the correction of her endocrinopathies.

The foregoing cases also illustrate the wisdom of correcting the simplest defects first. Next, a complete history should be obtained. Nowhere in medicine is a complete history more important than in the study of endocrine disorders. It should begin with the pregnancy which terminated in the patient's delivery and continue to the time she consults the physician for treatment. Women who are victims of hypothyroidism often gain an undue amount of weight during pregnancy. The following information is pertinent:

What did the patient weigh at birth? Hypothyroid babies are often large, while candidates for

* Presented before the Seventy-fourth Semi-Annual Meeting of the Eleventh Indiana Councilor District Medical Association, at Delphi, on October 17, 1945.

[1] Frank, Robert T.; Goldberger, Morris A.; Salmon, U. J.; and Felshin, Gertrude: Amenorrhea: Its Causation and Treatment, *J. A. M. A.*, **109**:1863-1869, (December 4) 1937.

obesity in later life often weigh six pounds or less at birth.

Was the patient breast fed? Mothers who are victims of hypopituitarism are often unable to nurse their babies. Perhaps they nurse the first one a few months, but cannot nurse succeeding ones. But with each pregnancy they gain more weight and develop other symptoms of pituitary deficiency. The patient often inherits the mother's pituitary deficiency.

At what age did the teeth erupt? Hypothyroidism is accompanied by delayed dentition, whereas in victims of pituitary deficiency the teeth may erupt at the normal age.

At what age did bed-wetting stop? Hypopituitarism is accompanied by a delay in this respect, or the habit may be stopped for a time and resumed at the age of ten to thirteen.

At what age were the menstrul periods established? Hypogonadism is accompanied by a delayed puberty. Hypopituitarism is sometimes responsible for a menorrhagic first period which is likely to be late in appearing. This is followed by an amenorrheal interval of several weeks, terminated by another profuse flow. This sequence may be repeated a number of times before the periods are regularly established. Headaches just before or after the periods, chilliness, and a craving for sweets are often experienced by the victim of hypopituitarism.

The obese woman who is a victim of hypopituitarism usually gives a history of having been a small baby. She was thin, active, and undersized until after some infection developed, such as mumps, measles, scarlet fever, or pneumonia, or some operation such as tonsillectomy or appendectomy, or until after pregnancy. Following any of these events she may have begun to gain weight rapidly, and coincidentally with it she developed the other signs and symptoms of hypopituitarism.

The victim of pituitary and thyroid deficiency is likely to be somnolent during the day and wakeful at night.

The victim of hypothyroidism is extremely sensitive to cold and enjoys hot weather. The victim of hypoadrenia is equally sensitive to cold, but is also adversely affected by hot weather. The patient who has hypopituitarism is not characteristically affected by extremes of temperature.

The victim of pituitary-thyroid-gonad deficiency may have inherited the disorder, so inquiry should be made as to the height and weight of the parents. The patient may be normal until overtaken by some childhood infection. After that the child gains weight rapidly, scholastic work falls off, and development of the genitalia ceases or is retarded. Growth in height may or may not be affected.

Infections often damage the pituitary, and probably through it the thyroid and gonads, so every child who has an acute infection should be watched for the above-mentioned symptoms. If any of them are noted, further study should be undertaken immediately to determine whether pituitary damage has occurred. If so, corrective measures should be undertaken at once.

The so-called "Fröhlich's syndrome" characterized by obesity and hypogonadism is extremely common. The treatment for this is so simple and so satisfactory that it should be undertaken as soon as the diagnosis is established. It is often argued that these children will eventually normalize themselves without treatment. That is probably true in many cases, but in others it certainly is not true. It is my contention that we have no right to subject any child to the hazard of arriving at maturity with the stigmata of obesity, a misshapen figure, and hypogonadism when we have at hand remedies adequate to prevent such a misfortune.

Treatment is easily carried out. They all need thyroid in such doses as can be tolerated without tremor, tachycardia, nervousness, or insomnia; they also need pituitrin in such doses as will not cause annoying intestinal cramps, nausea, or faintness. They require in addition either anterior pituitary extract or some gonadotrope such as antuitrin-S, A. P. L., et cetera. Those of average height or below will do better as a rule on anterior pituitary extracts because these tend to stimulate growth in height as well as development of the genitalia. On the other hand, those of more than average height should have some gonadotropic preparation with the idea of hastening closure of the epiphyseal lines.

Anterior pituitary preparations should be given in doses of 0.5 cc. two or three times per week. My feeling is that the gonadotropes should be given in doses of 50 to 100 units two or three times a week. Most men prefer larger doses. Treatment should be continued until the development of the genitalia reaches normal proportions.

Three precautions should be observed:

1. Guard against overdosage of thyroid, as already mentioned.

2. Check urine frequently—once every thirty or sixty days—for sugar. The administration of gonadotropic preparations is occasionally followed by glycosuria.

3. Avoid causing precocious sexual development. This can be done by occasional inspection of the genitalia. It is not likely to occur if moderate doses of the gonadotropin are used. If development seems too rapid, the anterior lobe extract or the gonadotropin, whichever is being used, should be stopped for thirty or sixty days. It sometimes happens that once development is started the body carries on without further assistance.

Therapeutic tests may be used to advantage in some cases. Hypothyroidism should be recognized by the history of mental and physical retardation, usually gain in weight, bradycardia, sensitiveness to cold, and by the physical findings. It sometimes simulates brain tumor, tabes, neuritis, ulcer, cholecystitis, pernicious anemia, or nephritis. In cases suspected of such disorders it is sometimes better, easier, and wiser to rule out hypothyroidism before subjecting the patient to the expense and in-

convenience of gastro-intestinal x-ray studies, lumbar puncture, et cetera. If the patient's symptoms clear up on the cautious administration of thyroid, one may conclude that the patient's trouble is hypothyroidism and proceed with treatment on that basis. Give the patient one grain per day for one week. If no signs of hyperthyroidism occur, as indicated below, increase the dose to two grains for another week, and so on.

It is said that during the administration of thyroid the basal metabolic rate should be checked frequently. In happier times that might be desirable, particularly with some types of patients, but it is rarely absolutely necessary, and during the present shortage of physicians it may be completely ignored. The patient should be seen at least once a week. When tachycardia, tremor of tongue or outstretched fingers occur, or the patient complains of heart consciousness, nervousness, or insomnia, the dose should be reduced about 25 per cent and continued at that level.

If thyroid is given to young girls the menstrual periods should be carefully checked. Occasionally periods of amenorrhea develop without other signs of hyperthyroidism. At the first sign of any menstrual disturbance the thyroid should be stopped.

The obese woman who has a headache may be suspected of hypopituitarism. Give her 0.5 cc. of obstetrical pituitrin, being careful not to give it closer than one week prior to her next menstrual period. If the headache is promptly relieved, that fact is strong presumptive evidence that her headache is due to pituitary deficiency and that she will be benefited by a series of such injections given twice a week.

A few days later she should be given 0.5 cc. of anterior pituitary extract. If this is also followed by relief of headache and a sense of well-being, that is additional evidence that the pituitary is at fault. Both extracts should then be given twice weekly. They may be given in the same syringe at the same time. The pituitrin should be omitted during the menstrual periods. Such women should also be given thyroid in such dosage as can be tolerated without tremor, tachycardia, nervousness, or insomnia.

It is generally assumed that the basal metabolic rate indicates the level of thyroid function; a low basal metabolic rate signifies hypothyroidism, and an elevated basal metabolic rate signifies hyperthyroidism. However, if a patient is found to have a low basal metabolic rate, but does not exhibit corresponding signs and symptoms of hypothyroidism, it may safely be assumed that the low basal metabolic rate is due to something other than thyroid deficiency. The low reading may be due to some non-endocrine condition or to pituitary or adrenal deficiency. Their different reactions to temperature have already been mentioned.

A therapeutic test will help to clarify the situation. The administration of thyroid in doses of two grains per day to an adult will within a week bring about some improvement in the victim of hypothyroidism, whereas the same dose of thyroid will make the patient with hypoadrenia more miserable, causing nervousness, tachycardia, and perhaps heart consciousness.

The injection of 0.5 cc. of anterior pituitary extract will within an hour or so give the victim of hypopituitarism a sense of well-being wholly different from his usual state.

Addison's disease is a very rare disorder. A definite diagnosis is difficult, particularly in the absense of pigmentation. The "water test,"[2] while not conclusive, is usually helpful and gives a general idea as to whether Addison's disease may be ruled out or whether the study should be pursued further. The test is conducted as follows:

The day before the test the patient eats his usual diet, but omits extra salt. After 6:00 P.M. he takes no food or drink. At 10:30 P.M. he voids and discards the urine. Any urine voided thereafter until and including 7:30 A.M. is collected and measured. At 8:30 A.M. the patient again voids and discards the urine. He is then given 9 cc. of water per pound of body weight. This he drinks in the course of forty-five minutes. He is asked to void at 9:30, 10:30, 11:30 A.M. and 12:30 P.M. Each of these specimens is measured. The volume of the urine voided during the night is compared with the largest single specimen voided between 8:30 A.M. and 12:30 P.M. If the volume of urine voided during the night is of smaller amount than the urine voided in any one hour during the morning, the patient can be assumed not to have Addison's disease. If on the other hand the volume of night urine is greater than the volume voided in any one hour during the morning, Addison's disease is suspected, and further studies are necessary.

A therapeutic test, while neither scientific nor conclusive, may be helpful at this time. The patient may be given sodium chloride in enteric-coated tablets, 3 to 6 grams daily, with 5 mg. of desoxycorticosterone acetate. If marked improvement occurs quickly there is at least a likelihood that the patient does have Addison's disease and that treatment should be continued until an opportunity permits a complete study to either vindicate or disprove the diagnosis.

Hyperinsulinism due to adenoma of the pancreas is an unusual disorder, but spontaneous hypoglycemia, particularly mild forms, is quite common. The endocrine disorders most often responsible are pituitary and thyroid deficiency. The best procedure for determining whether hypoglycemia is responsible for the patient's symptoms is by performing a glucose tolerance test. However, if the physician lacks facilities for doing this, or the patient cannot spare the time for it, considerable information may be had simply by asking the patient to note carefully the time when his symptoms occur, and then postpone the next meal for an

[2] Robinson, F. J.; Power, M. H.; and Kepler, E. J.: Two New Procedures to Assist in the Recognition and Exclusion of Addison's Disease. A Preliminary Report. *Proc. Staff Meet. Mayo Clinic*, **16**:577-683, (Sept. 10) 1941.

hour or so beyond that time. If the symptoms are due to hypoglycemia they are likely to be aggravated by this procedure. Or have the patient take a little food an hour before the time the symptoms usually occur. Their prevention by this maneuver is strong presumptive evidence of hypoglycemia. Or give the patient one grain of thyroid per day and injections of 0.5 cc. each of anterior and posterior pituitary extract twice a week. This procedure will sometimes relieve the symptoms in a short time.

Treatment of the menopause. It is said that most women pass through this period without needing anything more than advice and encouragement. Whether the statement is true is a matter of conjecture. But for those who need something more we have the various estrogenic preparations. Most of these are put up in a solution of oil carrying a certain number (1,000-10,000) I.U. per cc. It is well to begin with the smaller doses, usually 2,000 I.U. one or more times per week. If after two weeks the symptoms are not relieved, larger doses may be given. Some women are relieved by small doses, but seem to experience an aggravation of symptoms when larger doses are given.

Estrogens are now compressed in tablet form and implanted subcutaneously. This gives the body a constant supply for several weeks or months.

Estrogens for oral administration include premarin, stilbestrol, estinyl, benzestrol, and others. These have several advantages. They are less expensive than the estrogenic preparations for hypodermic use. They are effective by mouth, and thus relieve the patient of the expense and inconvenience of frequent injections. However, they have some undesirable side reactions, the most common being gastro-intestinal upsets. Most writers claim these occur infrequently. In my experience they occur often enough to limit seriously the use of such preparations. Stilbestrol seems to be the worst offender of the lot. Finally, in my experience they are seldom sufficient of themselves to control the symptoms of the menopause, and some injections of the estrogens in oil have to be given.

The climacteric is much more difficult to recognize in the male than in the female. Treatment consists of testosterone propionate. The optimal dose seems to be 25 mg. two or three times per week, depending on the patient's response. It is said to reduce the frequency and severity of anginal attacks in men of middle age and beyond. It is said[3] that about sixteen injections given twice weekly are needed to bring the symptoms under control. The frequency of injections may then be reduced.

The substance is also prepared in tablet form for subcutaneous implantation. Administered in this way it has a more even action and the need for frequent injections is obviated.

Some cases of essential hypertension have an endocrine basis and can be helped by endocrine therapy. This is particularly true of patients with hypertension who are victims of pituitary and thyroid deficiency. A quick way to make an approximate estimation of those likely to be benefited by such therapy is to give the patient an injection of 0.5 cc. anterior pituitary extract and check the blood pressure before and at fifteen-minute intervals after the injection. If the blood pressure falls markedly within an hour, it is quite likely that two or three such injections per week will be helpful. A much more thorough study should, of course, be made in time, but this procedure may be helpful to some hurried and harassed doctor. Diabetics should not be subjected to this treatment.

Low-dosage x-ray irradiation of the pituitary and adrenal regions is helpful in some cases of hypertension. The following factors have been found useful: 120 kilovolts, 50 cm. skin target distance, 2 mm. aluminum filter, 3 milliamperes, 50 r. to each area treated. Each side of the pituitary is treated through a portal 10x10 cm., and the adrenals through a common portal 15x15 cm. We have records of nearly four hundred cases. In about 90 per cent such symptoms as headache, vertigo, heart consciousness, precordial distress, and nervous tension have been relieved. In about 70 per cent there has been a worth-while reduction in blood pressure. By continuing these treatments when needed, as indicated by a rise in blood pressure, the lower levels of blood pressure can be maintained over several years. This has been true in about 58 per cent of our cases.

We have used this in the treatment of some intractable symptoms of the menopause, particularly headache which does not yield to estrogens.

Raab[4] has irradiated the adrenal region for angina and claims very good results. We have seen a few patients who seemed to have been helped considerably.

No claim is made that the foregoing remarks are scientific, nor do they indicate thorough study and ideal treatment of cases. The suggestions are offered only in the hope that they may save some hard-pressed doctor a little time and energy.

[3] Waldman, Samuel: The Treatment of Angina Pectoris with Testosterone Propionate, *J. Clin. Endocrinology*, **5**: 305-317, (September) 1945.

[4] Raab, W.: Roentgen Treatment of the Adrenal Glands in Angina Pectoris (One Hundred Cases), *Ann. Int. Med.*, **14**:688-710, (October) 1940.

MASSIVE ARSENOTHERAPY OF EARLY SYPHILIS*

H. H. RODIN, M.D.

SOUTH BEND

The story of syphilis is perhaps the most dramatic in the history of medicine. It represents a new world contribution to the old, instead of the reverse, as is usually the case. Shortly after the return of Columbus and his men to Spain, from what they thought was North America, a strange and terrible disease swept through their country. Since medicine had awakened from its long quiescence, the physicians of that day were able to record the symptoms very accurately. This disease was characterized by an initial lesion, genital or in many cases extra-genital, and an apparent cure, only to be followed by severe constitutional symptoms, a generalized rash, and a high mortality rate. About this time Charles VIII, the Hitler of his day, was in the process of successfully subduing Italy. After several of the Columbus' mercenaries joined his army it was suddenly struck by this strange disease and literally decimated, causing its withdrawal to France. So it went, from country to country, until the disease had spread through all of Europe. Stigmatization developed early, as it was quickly realized that the disease was spread through sexual contact. Thus, the Italians called it the French disease, the French called it the Italian disease, the Poles called it the Balkan disease, and the Russians called it the Polish disease. Each in his own way was, as it were, attempting to blame the other. In time, as with other diseases passing through virgin territory, it lost its malignant character, assuming more and more the benign picture as we know it today.

More interesting perhaps is the fact that there are physicians practicing today who have seen the whole drama of modern syphilis unfold during their lifetime of practice; something which is indeed rare as the full development of most diseases is spread over a span of many lifetimes. About a month ago I met such a physician in Chicago who told me that he well remembered the first injection of arsphenamine given in that city. He stated that the scene took place in the amphitheater of one of the medical schools, and that after the injection was completed the clinician turned to the audience and said, "Gentlemen, this patient is now cured."

About 1922 or 1923 the group composing the Health Division of the League of Nations decided that sufficient cases of syphilis had been treated to justify an international statistical analysis of the results. Incidentally, this work was probably the only worth-while contribution that the League made. At any rate, five countries were assigned to this study—England, France, Germany, Sweden, and the United States. In this country the work was divided among eight centers, which called themselves the Clinical Cooperative Group. All their records were gathered and turned over to lay statisticians, not doctors, because they wished the cold figures to speak for themselves, and not be colored by professional prejudice, et cetera. First, they analyzed all records as to methods used, and they found that all cases fell into one of the following four groups: (1) no treatment; (2) irregular treatment, that is, the salesman-type of treatment where an injection would be given if and when the patient would report at a doctor's office; (3) intermittent treatment, the method carried out by the conservative group, since these men felt that the patient developed a certain degree of immunity that must not be disturbed (they gave a course, then a rest followed by another course whenever the patient was in the mood to receive it); and (4) intensive therapy, the plan advocated by the radical group who felt that it was necessary to push treatment to the limit. Thus was born the modern conservative treatment of 30-0-60, meaning 30 injections of arsenic—no rest—and 60 injections of bismuth. These statistics were fed into the impersonal tabulating machine, which showed, without a shadow of doubt, that the best method was the 30-0-60 form of treatment, which showed a 95 per cent cure for darkfield positive serological negative cases; 85-90 per cent for the darkfield positive serological positive cases, and 80 per cent for the secondary cases. The records were then sorted as to complications of syphilis, and the results were identical. Tabulating the records backwards or forwards, the best results were obtained by the methods advocated by the radicals of the 1920's.

The question then naturally arises, why should attempts be made to find a quicker method of treatment if the 30-0-60 course gives good results, particularly in the primary sero-negative phase? The answer lies in the fact that the most important finding by the Clinical Cooperative Group was that lapse in treatment, even one, regardless of the cause, resulted in a drop in the percentage of cures. As is well known, few patients complete ninety weeks of continuous treatment without one or more lapses, due either to illness or vacations on the part of the patient or the doctor, and this is particularly true of the clinic patient.

About 1932, Dr. H. T. Hyman, of Mount Sinai Hospital, New York, a physiologist, was working on the cause of reaction produced by the intravenous injections of large quantities of fluid. He discovered that the rate of injection was one of the principal factors, and this condition later be-

* Presented before the St. Joseph County Medical Society, at South Bend, Indiana, on October 9, 1945.

came known as "speed shock."[1] He found that large quantities of fluid could be administered safely if given slowly, and thus was developed the intravenous drip technic. He also discovered through animal experimentation that toxic or lethal doses of any drug could be raised if given by this drip technic. Dr. Louis Chargin,[2] a syphilologist connected with the Department of Dermatology, who was being plagued by the problem of lapses, decided to apply this principle in the development of a new rapid-method of treatment. So, in 1933, a series of volunteers, twenty-five in number, with primary and secondary syphilis were given neoarsphenamine in doses of 4 to 4.5 gms. by continuous intravenous drip in five days. They decided that they would limit the experiment to twenty-five patients, and that they would watch them for five years. At the end of this period they had lost control of ten patients, but of the fifteen remaining, 86.6 per cent were found to be cured. Since the results were at least as good as the conservative continuous treatment, they felt encouraged to continue their work. About this time mapharsen was introduced, and because of the high incidence of toxic reactions with neoarsphenamine, particularly polyneuritis, and one fatal case of hemorrhagic encephalitis, they substituted this drug. It was found through trial and error methods that 1,200 mgm. of mapharsen gave results comparable to the neoarsphenamine series. By the fall of 1938 eighty-six additional patients had been treated, and the follow-up at the end of two years revealed 91 per cent to be clinically and serologically negative. The Mount Sinai Group felt that they now had something worth while, so they suggested further studies be carried out by other groups. As a result a new Clinical Cooperative Group was formed and the work assigned to various centers throughout the United States.

FIVE-DAY PLAN

One of the members of this group was the Cook County Hospital, where the studies were carried out under the supervision of Dr. Herbert Rattner,[3] and the discussion of the five-day intensive treatment is based on observations made in that institution. In the beginning only healthy male patients who had primary and secondary syphilis were treated—males only, because the only available room was located on the men's service. All patients received complete physical examinations which included x-rays, chest plates, and complete laboratory work, with blood chemistry, such as N.P.N. cholesterol and blood sugar determinations. In the beginning each patient received .24 gm. mapharsen dissolved in 2,000 cc. 5 per cent glucose by the drip technic in ten hours for five days, the total dose being 1.2 gm. mapharsen. One day one of the patients decided the solution was dripping too slowly, so he reached up and loosened the clamp so that the solution ran in faster, and he received the total dose in eight hours. Since no reaction resulted, all subsequent cases were treated in this period of time. One consultation was requested in the obstetrical ward, where a primigravida at full term was found with a chancre on the labia. Since the lesion was located in such a position that neither the baby nor the interns could avoid the chancre on delivery, it was decided to treat her, with the obstetrical department standing by to perform an emergency section. She was placed on the five-day treatment, and at the end of twenty-four hours the lesion became darkfield negative, and at the end of forty-eight hours she delivered. The treatment was then continued for the full five days. The infant was born free of syphilis, as subsequent clinical and laboratory examinations were negative. It was felt that pregnancy was no contraindication for treatment and that the fetus could tolerate at least .48 gm. arsenic without harm. Later other pregnant cases were treated at various stages of pregnancy, and in all cases normal infants were born. In fact, one case was treated early in her pregnancy and was cured, only to return one month prior to term with a reinfection. She was treated again and delivered a normal baby. Thus the fact became established that a person could be retreated without harm and the fetus could tolerate 2.4 gm. arsenic. As confidence was gained, other patients with other diseases were treated. Finally it was decided that nephritis and hepatitis were principally the only contraindications for this treatment.

The incidence of minor toxic reactions, such as temperature, nausea, vomiting and arm pain, were high, but they did not interfere with successful completion of treatment. There were also several serious toxic reactions, such as nephritis and hepatitis, and two cases of hemorrhagic encephalitis.[4] Out of a total of 550 cases treated there were no fatalities because of heroic work on the part of the resident in charge. However, it must be emphasized that all of these cases were under the constant observation of a specially-trained nurse and two residents, who were ready to stop treatment and apply counter-measures at the instant that it became necessary. No allergic reactions, such as erythema of the ninth day or Herxheimer reactions, were noted because the treatment was given under the incubation period, which is usually ten days.

A follow-up of 100 cases revealed 80 per cent cures and 20 per cent relapses. Consequently, bismuth was added and was given as a water soluble preparation on the first, third, and fifth days. This resulted in an improvement of 6 to 7 per cent in the number of cases, bringing the total to 86 per cent. However, the reports from the other

[1] Hyman, H. T., and Hirshfield, Samuel: *J.A.M.A.*, **100**:305-310, 1933.

[2] Chargin, Louis; Leifer, William; and Hyman, H. T.: *J.A.M.A.*, ***104***:878-883, 1935.

[3] Rattner, Herbert, and Falls, A. B.: *J.A.M.A.*, **118**:1368, 1942.

[4] Rattner, Herbert: *J.A.M.A.*, **122**:986-989, 1943.

groups revealed a mortality incidence of 1 to 300 cases treated. This, of course, at first glance appears as an abnormally high figure, one high enough to consider this method as dangerous. On the other hand one may raise the question as to the mortality rate of the conservative treatment. Actually no one knows, since many cases die in physicians' offices which are not reported as arsenical deaths. For example, at one of the American Medical Association meetings an exhibit illustrating the five-day treatment was presented. A layman was placed in charge, to answer questions, and on the second day he reported that at least a dozen physicians had volunteered the information that they had a patient die in their office from an injection of arsenic. He was given a note book and told to record all such incidences, and in the next three days he recorded seventy-five cases.

FIVE-DAY AMBULATORY PLAN

Shaffer[5] attempted to modify this treatment in order to place it on an ambulatory basis. The mapharsen was dissolved in 1,000 cc. 5 per cent glucose solution and given rapidly by gravity, requiring sixty to seventy-five minutes daily for five days. The incidence of severe toxic reactions and a fatality of 1-100 cases treated quickly caused this method to be discontinued.

TEN-DAY PLAN

Another[6] method of intensive treatment was described by Thomas and Wexler. Their patients were given two injections of mapharsen of 60 mg. each, six to eight hours apart for ten days, for a total of 1,200 mg. The incidence of fatal hemorrhagic encephalitis resulted in three out of 226 patients. Thomas since has advised against the use of this treatment.

ONE-DAY PLAN

Simpson,[7] et al., treated a group of patients with the one-day system. Their therapy consisted of an intramuscular injection of bismuth, ten hours of artificial fever, and mapharsen during the febrile period. The arsenic was given in a dosage of 1.75 mgm. per kg. in three divided doses. The first dose was given when the temperature reached 106 F. (rectal) the second dose at the beginning of the third hour, and the third dose at the fifth hour of maintained fever.

Jones[8] modified this treatment by giving 2 mgm. of mapharsen per kg. at the termination of five hours of fever at 106 F. The calculated dose was dissolved in 250 cc. 5 per cent glucose and injected intravenously by rapid-drip method, completing the injection by the time the temperature dropped to 105 F. Two hundred eighty patients were treated without serious reaction.

TWELVE-WEEK PLAN

Eagle[9] devised a method of treatment based on animal experimentation, which consisted of giving mapharsen three times weekly for twelve weeks, and one injection of bismuth (2 gm.) weekly—a total of thirty-six injections of mapharsen and twelve injections of bismuth. This system of treatment has been much less hazardous than the more intensive systems, and the therapeutic results are very gratifying.

TWENTY-SIX-WEEK PLAN

The Army of the United States has been using a system of treatment which is completed in twenty-six weeks. The treatment consists of giving two injections of mapharsen 60 mgm. each, and one of bismuth salicylate 1.5 cc. per week for five weeks; two injections of mapharsen 60 mgm. per week for five weeks; one injection of bismuth salicylate for six weeks, and two injections of mapharsen 60 mgm. each for five weeks; one injection of bismuth salicylate 1.5 cc., and two injections of mapharsen 60 mgm. each for five weeks. On this schedule the patient receives forty injections of mapharsen and sixteen injections of bismuth salicylate. Experience has shown that the hazards are about the same as those encountered with routine orthodox therapy.

THIRTY-DAY PLAN

Goldblatt[10] very recently described preliminary results with a thirty-day syringe technic. He dissolved 60 mg. of mapharsen in 5 cc. of distilled water and injected it daily for thirty consecutive days. His results are comparable to those obtained with other forms of intensive therapy, and the toxic manifestations seemed to be minimal.

CONCLUSION

Although most investigators have limited their work to early infectious syphilis, a few have ventured to treat all types of syphilitic involvement. Dattner[11] treated 276 patients with neurosyphilis with malaria, followed by daily injections of 60 mg. mapharsen for ten days. Goldblatt treated all types of syphilitic involvement with his system. Alexander and Schock[12] treated 350 cases of early latent syphilis by the Eagle method. Because the observation time has not been long enough, it has not been possible for any of these investigators to draw any conclusions, other than that the immediate results are encouraging.

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[5] Shaffer, L. W.: *Ven. Dis. Inform.*, **24**:108-113, 1943.

[6] Thomas, E. W., and Wexler, Gertrude: *Arch. Dermat. and Syph.*, **47**:553-568, 1943.

[7] Simpson, W. M.; Kendell, H. W.; and Rose, D. L.: Supplement No. 16 to *Ven. Dis. Inform.*, 1942.

[8] Jones, Nathaniel; Carpenter, C. M.; Bock, Ruth A.; Warren, S. L.; and Hansen, Henry: *Ven. Dis. Inform.*, **25**:99-103, 1944.

[9] Eagle, Harry, and Hogan, R. B.: *Ven. Dis. Inform.*, **24**:33-44, 1943; **24**:69-79, 1943; and **24**:159-170, 1943.

[10] Goldblatt, Samuel: *Arch. Dermat. and Syph.*, **49**:403-407, 1944.

[11] Dattner, Bernard; Thomas, E. W.; and Wexler, Gertrude: *Am. J. Syph. and Ven. Dis.*, **28**:265-285, 1944.

[12] Schoch, A. G., and Alexander, L. J.: *Arch. Dermat. and Syph.*, **46**:128-129, 1942.

The most feared reaction[13] is hemorrhagic encephalitis, and during the early experiences with intensive arsenotherapy the reported incidence was one patient in every one hundred cases treated, with one death in every 300 patients. As compared with the incidence encountered in routine orthodox therapy, this number is exorbitant. With experience and a more careful selection of patients this reaction was decreased 50 per cent.

Other reactions have been toxic hepatitis, primary and secondary fever, chills, toxicoderma, pain in arm, nausea, vomiting, renal damage, and neuritis. Toxic hepatitis, toxic erythema, and renal damage are strong indications for discontinuance of treatment. Jones and his co-workers have definitely shown that fever enhances the toxicity of mapharsen. This, however, is in direct contrast to Rose, Simpson, and Kendall, who found it to be less toxic.

Intensive therapy of syphilis has emphasized the necessity and value of doing quantitative serologic determination.

In the work done on the five-day method, the Kahn quantitative test was used. This method makes use of an arbitrary factor multiplied by the serial dilutions and is reported as units. For example, a case treated by this method revealed the following:

	Kahn Qualitative	Kahn Quantitative
Treatment Time	4+	480U
1st week after treatment	4+	360U
2nd week after treatment	4+	280U
3rd week after treatment	4+	120U
4th week after treatment	4+	80U
5th week after treatment	4+	40U
6th week after treatment	3+	20U
7th week after treatment	2+	10U
10th week after treatment	0+	0U

Obviously, if a quantitative test had not been used it would have been impossible to determine the progress of this disease. It was also noted that the serology would relapse first, for example at the end of seven weeks the Kahn quantitative showed 20 Kahn units, the eighth week 40 Kahn units, and the ninth week 60 Kahn units, but no clinical evidence would be present until 80 to 120 units were reported. Since it is imperative to prevent clinical relapses which are infectious, it is necessary to re-treat the case while it is in the relapsed serological phase. The majority of relapses occur within the first six months following termination of treatment. However, it must be emphasized that it is not necessary to use the Kahn test, as the serial dilution of any of the standard tests, such as Wassermann, Kline, or Mazzini, et cetera, will do. The highest dilution which gives a positive reading is considered the serological titer.

The information which has been gathered shows that the therapeutic results to be expected from the various forms of intensive arsenotherapy, with the addition of bismuth, ranges from 74 to 91 per cent cures. Fever also enhances the results of low-dosage arsenotherapy.

[13] Alexander, Lee; and Schock, Arthur G.: *Clinics*, 3: (No. 4) 960-971, 1944.

SUMMARY

(1) It is obvious from the review of the various treatments that the short-term intensive arsenotherapy of syphilis is too hazardous for general use and should be used only in hospitals or treatment centers which have well-trained personnel.

(2) The safer, long-term methods of intensive arsenotherapy, such as the Eagle tri-weekly methods, the Army twenty-six-weeks plan, or the thirty-day daily injection system can be recommended for general use. The results of treatment are satisfactory with all these methods, and they can be used on an ambulatory basis.

(3) The routine conservative continuous schedule of 30-0-60 for early syphilis will probably soon be used only in the minority.

(4) The addition of bismuth or fever to mapharsen yields better results than mapharsen alone.

(5) Fever enchances the toxicity of mapharsen and therefore must be used with caution.

(6) Quantitative serologic tests are essential to the proper management of intensive therapy.

ABSTRACT

INFECTIOUS COLON DISEASES SUCCUMB TO SULFATHIAZOLE DERIVATIVE

A new sulfathiazole derivative, phthalylsulfathiazole, or sulfathalidine,has been found to be superior to other drugs in the treatment of infectious diseases of the colon, according to Michael R. Streicher, M.D., of Chicago.

Writing in the December 15 issue of *The Journal of the American Medical Association*, Dr. Streicher, who is assistant professor of Medicine at the University of Illinois College of Medicine, said that his experience led him to believe that this drug, taken by mouth, was less poisonous and more effective in arresting the growth of bacteria "than any intestinal agent used previously."

The author treated one hundred patients with this drug, eighty of whom had chronic ulcerative colitis. The others were suffering from other infections of the colon. Dr. Streicher wrote that with sulfathalidine treatment of the one hundred patients under study, eighty-four demonstrated good results, six showed fair results, and ten patients showed poor reaction to treatment.

Chronic ulcerative colitis is a disease marked by numerous ulcerations in the colon; it has a chronic course with periods of abatement of the symptoms, and then periods in which the disease increases in severity. It usually affects young and middle-aged adults. The symptoms are abdominal cramps, fever, and weakness. As time goes on there is progressive emaciation, anemia and weakness, and the blood pressure falls.

DEEP BURNS INVOLVING BONES*

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SAINT LOUIS, MISSOURI

Burns deep enough to involve bones are nearly always the result of the patient being pinioned in flaming wreckage. They are usually fatal, the survivors being those who are able to extricate themselves quickly or who are rescued by others.

Illustrative cases seen recently include (a) a trainman who had one leg caught in flaming wreckage and could not be freed for several minutes

FIGURE I-A



Circular deep burn of leg from the knee to the ankle with all of the skin lost and the anterior face of the tibia dead from the knee to just above the ankle.

(Fig. I-a and I-b); (b) a man who was trapped under a wrecked car with the motor running and with his head against the exhaust pipe (Fig. II); (c) a worker who spilled molten metal into his boot; (d) a woman who was heavily sedated and in a bed which caught fire from an electrical heating pad; (e) a man who took hold of a high tension electrical wire and could not let go of it; (f) a janitor whose feet and legs were caught in flaming wreckage from a furnace explosion; (g) another trainman who had both legs caught in burning wreckage; and (h) a truck driver who had one foot and leg caught under his burning vehicle for several minutes. Several of these patients were unconscious for a time after the accident (from concomitant head injuries, or in one instance from oversedation), but were quickly rescued by other persons.



FIGURE I-B

Result from cleaning the leg, split grafting all around it to the edges of the exposed bone, and sequestrectomy a few weeks later. After the dead anterior plate of the tibia was removed granulations appeared and were thick enough to receive another strip of split graft three weeks later. Patient soon resumed heavy manual labor and has no gait disturbance. Remains solidly healed to date (three years later).

The bones involved were the superficial ones, namely, the skull, the anterior surface of the tibia, bones of the hands and feet, the olecranon and upper ulna, and the humerus in one patient who was quite thin.

Most of the above patients were first seen a few days to a few weeks after the accident. In those who were seen earlier it was evident that the burns were deep from the extensive carbonization of the soft tissues, which, however, still covered the bones. The fact that the bone was burned, in any given instance, could not be determined definitely until the soft tissue slough separated (usually one to three weeks), or was surgically removed, revealing the dead white bone underneath which did not bleed from the surface and which turned yellowish-black within a few days.

FIGURE II



(A) (B)

(A) Burned area of skull is seen, with surrounding granulating scalp area. Patient also had a large deep burn of the shoulder region. All granulating areas were prepared for split grafting and covered in one operation. The outer table of the skull separated a few weeks later. Granulations quickly grew up from the inner table and epithelium across from the sides to finish healing the defect with result shown in (B). Patient could have a scalp flap switched over the area, but his hair covers it and it gives him no trouble.

Some of the patients seemed to have an unusual amount of pain during the first few days, and this may have some prognostic import. They did not have an unusual amount of fever or leukocytosis,

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nor did they appear especially septic at any time (except in one patient in whom there was a delay in draining a soft tissue abscess). Early roentgenograms were obtained in only two instances and were not particularly helpful. Later ones, of course, showed the extent and progress of the sequestration. These sequestrae usually separated in two to three months, all, or nearly all, of the dead bone being removed at one time.

Early treatment consisted in combatting the shock and correcting any derangement of the body fluids, cleansing the involved areas, and applying pressure dressings with fine mesh grease gauze next to the wounds. Dressings were changed the first few times whenever they became dirty or loose, usually at intervals of four to seven days. After the first ten days or two weeks the dressings were changed daily or every other day, and some debridement of necrotic tissue was done at each dressing. Whenever enough slough was partially separated to justify it, an anesthetic was given and surgical excision was done. Pressure dressings were used at all times. Fine mesh grease gauze was ordinarily used next to the wounds, changing to wet dressings when necessary to hasten separation of the slough or to treat cellulitis of the wound edges. The slough was usually off within one to three weeks, and the surrounding viable soft tissues were covered with fine, bright red granulations suitable for the reception of grafts within four to six weeks after the burn. The dead bone did not seem to be especially good culture media for the organisms present, and the granulations became clean about as quickly as usual.

Grafting was not done until practically all of the granulating surfaces were clean, and they were all covered with split skin grafts at one time, without waiting for the dead bone to separate. Complete, or nearly complete, take of the grafts was obtained in all instances, extending right up to the edge of the burned bone. The dead bone showed signs of separating a few weeks later and was ordinarily pried loose with a periosteal elevator. Within about ten days after removal of the bone, the bed would be covered with granulations. Grafting was done again at this time if the area was large, or it was allowed to heal spontaneously, if small. Thus, one or two grafting operations sufficed to get healing in all patients.

It was thought best to get the patients healed quickly with split grafts, and then switch flaps over any of the bony prominences later, if necessary. In this small group it has not been necessary to switch any flaps secondarily, although it is still a likely possibility in any such patient. In one instance sequestrae were pried off and split skin grafts applied immediately to the underlying cancellous bone, with excellent "takes." Grafts did not take on dense, cortical bone. In two patients there was later discharge of a few tiny bone chips through the grafts before final permanent healing.

Amputation of some phalanges was necessary when they were burnt completely through, but proximal segments were saved even when some bone in them was destroyed. It was necessary to amputate one foot in which all of the tendons (including the Achilles) were necrotic and complete anesthesia was present. The extensive burns surrounding the thigh and leg in this patient were covered with split grafts first, reserving the amputation until the last.

Not included in this series is a considerable group of patients in whom a segment of the mandible has been destroyed with the cautery for eradication of cancer. These burned jaw fragments usually separate quite cleanly within two to three months.

SUMMARY

1. The possibility of a burn extending into bone may be considered when the part has been in contact with flame or hot metal for several minutes and when the locale is one in which the bones are superficial.

2. The diagnosis is obvious after the separation of the soft tissue slough. Early roentgenograms are of little value.

3. The surrounding soft tissue areas should be cleaned and grafted as soon as possible without waiting for the bone to separate. The dead bone does not interfere with the take of split grafts, and it can be removed a few weeks later.

4. These burns often extend just partially through the bone. For this reason amputation can usually be avoided, and any decision to the contrary should be reached reluctantly and after all other areas are healed.

ABSTRACT: METHYL ALCOHOL POISONING

Four Navy doctors, who made a study of methyl alcohol poisoning, believe the essential principle of treatment is the correction of acidosis with an alkali, such as soda.

The doctors, who reported this study in the January 12 issue of *The Journal of the American Medical Association*, are: Commander W. B. Chew, Commander E. H. Berger, Captain O. A. Brines, and Captain M. J. Capron, of the United States Naval Reserve.

Of thirty-one military personnel patients suffering from wood alcohol poisoning, and under the care of these doctors, five died within three hours after admission to the hospital. The rest recovered and were returned to duty. The authors felt that their success was due to the prompt elimination of acidosis, sometimes called acid intoxication.

Methyl alcohol poisoning usually results in blindness or death. The poison seems to have a selective effect on the optic nerve and retina of the eyes. The symptoms are usually delayed for nine to thirty-six hours, during which time an individual may continue to carry on. Suddenly weakness, headache, nausea, vomiting, and collapse occur. If death does not come first, then the coma may last for several days before improvement occurs. Permanent blindness is then a frequent result.

HYSTERECTOMY*

Indications for the Various Types of Operation

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It may appear uninteresting and monotonous to discuss such a threadbare subject as hysterectomy, an operation which has been performed in this country for the past hundred years. This operation is so common that it is performed thousands of times a year, and in every hospital where surgery is practiced.

For most surgeons familiar with gynecologic disorders the indications for removal of the uterus, in a general way, have become standardized. But during the past few years voluminous literature has accumulated on the subject of subtotal and total hysterectomy, and the route, abdominal or vaginal, by which the uterus should be removed. With improvements in surgical technique permitting more extensive operations, it has become the common practice of many surgeons to remove the entire uterus, and in many cases to perform the operation vaginally.

As a basis for discussion of the more common indications for hysterectomy, and also of the choice of the procedure in removing the uterus, statistics on a small group of personal cases and comparative statistics from gynecological clinics and general hospitals are presented.

In Table I is an analysis of 228 hysterectomies personally performed on private patients during a ten-year period prior to October 1, 1945. Hysterectomies following cesarean section are not included in this study. As is usual, the most frequent pathology requiring the removal of the uterus was myoma. Small myomas which cause no symptoms do not require any treatment, but when hemorrhage, which is usually menorrhagia, or pressure symptoms appear treatment is indicated. There are three accepted methods of treating uterine myomas: excision of the tumor alone, or myomectomy, which may be performed either vaginally or abdominally; hysterectomy; and radiation. Vaginal excision of a pedunculated submucous myoma which extrudes through the cervix is a simple procedure, as is abdominal myomectomy of one or more subserous or intramural myomas, but cases suitable for these procedures are in the minority. It is only where the preservation of the childbearing function is a factor that the operation of abdominal myomectomy is applicable. The vast majority of patients with multiple or large myomas are best treated by hysterectomy. Frequently, extraordinary attempts to preserve the uterus necessitate further surgery. The uterus which contains large symptom-producing myomas is not likely to carry a pregnancy to term. By surgery one can make an exact diagnosis and take care of other pelvic pathology. Also by surgery ovarian function, which is destroyed by radiation therapy, can be preserved in young women.

TABLE I.

INDICATIONS AND TYPES OF OPERATION IN TWO HUNDRED TWENTY-EIGHT PRIVATE CASES

Pathology	Subtotal	Total	Vaginal	Number of Cases
Myomas	69	17	.....	86
Prolapse	.....	.....	58	58
Pelvic inflammatory disease	28	10	.....	38
Benign bleeding	22	9	.....	31
Myomas and prolapse	.....	.....	4	4
Myomas and endometriosis	4	.....	.....	4
Endometriosis	3	.....	.....	3
Carcinoma of the uterus	.....	3	.....	3
Chorioepithelioma	.....	1	.....	1
TOTAL	126	40	62	228
PER CENT	55.3	17.5	27.2	100
AGE OF PATIENT	21-50	30-52	34-66	.....
MORTALITY	1	.....	1	.....

It is to be remembered that the uterus that once produces myomas is quite likely to do so again if uterine musculature remains prior to the menopause. As far as we know, the uterus possesses no function except to nurture the embryo from conception to the time that it is capable of external existence. It has been suggested, but has never been proved, that the uterus possesses endocrine function.

There is considerable evidence that removal of the uterus does not affect ovarian function. Jones and TeLinde[1] were able to demonstrate the normal excretion of pregnandiol, the excretion product of the corpus luteum hormone, after hysterectomy. Johnson[2] studied for four years, by vaginal biopsy, sixty women after total hysterectomy and found evidence of normal estrogen activity. Vasomotor symptoms characteristic of the menopause have not been observed in younger women following hysterectomy.

In patients where operation is contraindicated or at an age when the preservation of ovarian function is not essential, radiation of small myomas causing hemorrhage is an alternative method of treatment, but it has a limited field of usefulness and at present is not extensively practiced.

In this series, myomas of the uterus were associated with uterine prolapse in four cases. Vaginal

* Read before the St. Joseph County Medical Society, at South Bend, on November 27, 1945.

[1] Jones, G. E. Seegar, and TeLinde, R. W.: *Am. J. Obst. and Gynec.*, **41**:682, 1941.

[2] Johnson, W. D.; *South. M. J.*, **36**:23, 1943.

hysterectomy and repair was obviously necessary to cure the prolapse of the uterus and the associated cystocele. In four cases the myomas were associated with endometriosis, and removal of the uterus was the advisable procedure because of the raw surface left in freeing adhesions.

The surgical treatment of prolapse of the uterus in this country almost has become limited to two operations, vaginal hysterectomy and some modification of the Manchester operation. Where uterine prolapse is complete or is present to such an extent as to require surgery, and is associated with any uterine pathology, by vaginal hysterectomy the uterus can be completely removed and the pelvic supportive structures repaired. The contraindications to vaginal hysterectomy are usually pelvic inflammatory disease with adhesions, very large tumors, or previous pelvic operations. If the uterus is movable and contains only small tumors it may be removed by morcellation, vaginally. In this series the uterus was removed vaginally in sixty-two cases, with one death from peritonitis. In two cases the results were unsatisfactory and subsequent operations were necessary to cure an enterocele of the cul de sac which was not properly taken care of at the time of the hysterectomy.

Thirty-eight hysterectomies were performed in the course of operations for pelvic inflammatory disease in which the uterus contained no myomas. It has been our experience, as well as that of others, that when the uterus is left behind following operations for residues of pelvic infection, pelvic pain, dyspareunia, abnormal bleeding, and leukorrhea have frequently persisted and occasionally necessitated another operation to remove the uterus. We have been so impressed by this fact that we seldom do a simple salpingectomy. Such practice is now common in most gynecological clinics.

In women near the menopause, and sometimes in younger individuals, removal of the uterus may be necessary to control hemorrhage of endocrine origin. Hysterectomy not only controls the bleeding permanently, but permits the establishment of an accurate diagnosis. In one case hysterectomy was necessary in a woman twenty-one years old. This was done after two years' trial with endocrine therapy and two curettements.

Total hysterectomy is the principal treatment of carcinoma of the endometrium. If the operation is done early in the disease good results follow complete removal of the uterus, tubes, and ovaries. Control of hemorrhage, arrest of growth, and destruction of metastatic foci can be accomplished by radiation. Our present knowledge of the treatment of carcinoma of the fundus would indicate that the patient should have the advantage of surgery and also radiation administered pre- or post-operatively, or both.

While surgery is the principal treatment in carcinoma of the uterine fundus, it is not the accepted treatment of the more frequent form of uterine carcinoma—that of the cervix. Fifty years ago, before the therapeutic effects of x-ray and radium were known, cures of cervical carcinoma were accomplished by extensive removal of the pelvic organs. This extensive surgical procedure became known as the Wertheim operation and was accompanied by a very high operative mortality and a low percentage of permanent cures. The use of radium and its proved effectiveness ended what was known as the surgical era in the treatment of cervical carcinoma. But during the past few years some attempts have been made to revive surgery in the treatment of cervical carcinoma, and in expert hands in young, thin, and otherwise healthy individuals with very early lesions the results compare favorably with those of radiation therapy. Until we have more evidence of the value and safety of surgery we must assume that hysterectomy is not the treatment of cervical carcinoma as it is of fundal carcinoma.

In Tables II and III are some comparative statistics of the type of hysterectomies in seven large clinics and two general hospitals. The difference in the performance of the total operation in different institutions is rather striking. These reports indicate definitely that the trend is toward the complete operation in institutions where a large volume of pelvic surgery is done.

There are many reasons why the cervix should be removed with the body of the uterus, and there are also certain conditions where only the subtotal operation should be performed. Favoring the subtotal operation, it is said that it requires less skill and experience, and that there is less chance of infection and less danger of injury to the bladder and ureters. Endometriosis and extensive pelvic infection may render the total operation inadvisable because of danger of injury to contiguous organs.

The most important reason advanced for removal of the cervix is the occurrence of malignancy in the retained cervical stump. About 80 per cent of all uterine carcinoma is cervical. In reports of large series of cases of carcinoma of the cervix the incidence of stump carcinoma is about 5 per cent, not considering cases where the operation was performed less than a year previously. In these it is likely that the carcinoma of the cervix was present at the time of the operation. More than 2 per cent of all deaths in women are due to uterine carcinoma, according to both insurance actuaries and our local health department statistics. But this does not mean that 2 per cent of all women who have had subtotal hysterectomies die of carcinoma of the cervix. Henriksen[3] followed 6,550 cases of subtotal hysterectomy performed at Johns Hopkins Hospital and found that carcinoma subsequently developed in the stump in only .45 per cent of the cases. It is likely that these cases were carefully selected and the retained stump was given appropriate treatment. It appears that adequate treatment of benign cervical lesions has some effect in the prevention of

[3] Henriksen, Erle: *Am. J. Obst. and Gynec.*, **37**:452, 1939.

TABLE II.

COMPARATIVE STATISTICS

	Number of Cases	Subtotal	Total	Vaginal
Tyrone[4]	764	316	137	311
Miller and Prejean[5]	828	255	374	199
Danforth[6]	1,319	744	150	425
Weir[7]	1,914	348	1,436	130
Phillips[8]	980	253	643	84
McKinnon and Counseller[9]	2,684	764	1,920	.....
Vogt and Hamilton[10]	500	81	419	.....

TABLE III.

HYSTERECTOMY OPERATIONS PERFORMED IN TWO GENERAL HOSPITALS IN YEARS 1943 AND 1944

	Number of Operations	Total Abdominal		Subtotal		Vaginal	
		Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospital No. I	210	57	27.5	121	57.0	32	15.5
Hospital No. II	273	18	7.0	237	86.0	18	7.0

malignancy. We have done more than 5,000 cauterizations of the cervix, and in no case, to our knowledge, has a carcinoma later developed. Many of these were destruction of simple nabothian cysts or cauterizations following delivery. This chance observation does not mean that cauterization will prevent the development of all carcinomas of the cervix, but it is likely that in some cases cells with malignant potentialities were destroyed. Likewise, this observation does not imply that cauterization in any way compares with removal of the cervix. If the cervix is not removed it should be thoroughly treated pre- or post-operatively if diseased and examined at regular intervals.

Removal of the cervix at the time of hysterectomy requires only about fifteen minutes and is a continuation of the subtotal operation. In cases free from extensive inflammatory disease or endometriosis, injury to the bladder or ureters is unlikely in competent hands. Aside from danger of malignancy, the cervical stump may be infected, causing chronic leukorrhea or bleeding, or it may be the site of benign lesions, such as polyps and cysts.

In the past few years there has been a remarkable increase in the performance of vaginal hysterectomy. It has long since been demonstrated that abdominal operations for uterine prolapse have been either ineffective, as in the case of round ligament shortening, or unsatisfactory and troublesome, as in the case of attachment of the uterus to the anterior abdominal wall. Also, no abdominal operation can cure cystocele or enterocele, which so commonly accompany uterine prolapse. No operation other than vaginal hysterectomy is as satisfactory for procidentia. However, for lesser degrees of prolapse, plastic procedures are satisfactory, especially in young women. Vaginal hysterectomy can be done with less shock than the abdominal operation, and can also be done under local, spinal, or general anesthesia. It can be combined with plastic operations on the vagina and perineum, and permits routine removal of the cervix. The vaginal operation is also followed less frequently by thrombosis and embolism. The only particular requirements for the procedure are definite knowledge of the anatomy of uterine supportive structures and familiarity with the technique of vaginal operations.

[4] Tyrone, Curtis H.: *Ann. Surg.*, **107**:836, 1938.

[5] Miller, Hilliard E., and Prejean, Orin: *Am. J. Obst. and Gynec.*, **42**:580, 1941.

[6] Danforth, W. C.: *Am. J. Obst. and Gynec.*, **42**:587, 1941.

[7] Weir, W. C.: *Am. J. Obst. and Gynec.*, **42**:285, 1941.

[8] Phillips, Joseph H.: *Am. J. Obst. and Gynec.*, **50**:174, 1945.

[9] McKinnon, D. A., and Counseller, Virgil S.: *Surg. Gynec. and Obst.*, **74**:957, 1942.

[10] Vogt, William H., Jr., and Hamilton, Eugene G.: *Am. J. Obst. and Gynec.*, **44**:723, 1942.

SUMMARY AND CONCLUSIONS

1. A small group of personal cases and also statistics on hysterectomy operations from large teaching clinics and general hospitals are reviewed. These studies indicate that the trend in pelvic surgery is to remove the entire uterus when hysterectomy is performed, and to do the operation vaginally when conditions permit.

2. From the standpoint of operative technique and safety the subtotal operation is preferred by the occasional operator, and also in cases of extensive pelvic inflammation or endometriosis.

3. Because of the danger of the development of malignancy and the persistence of chronic infection in the cervical stump, the total operation should be the operation of choice for those familiar with pelvic surgery.

4. Vaginal hysterectomy definitely is becoming the choice operation for the correction of uterine prolapse and removal of the uterus in the same procedure.

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PERCUTANEOUS TUBERCULIN THERAPY IN BEHAVIOR DISORDERS OF CHILDREN

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Behavior defects in children are a source of worry to parents and an irritation to teachers and playmates. Frequently no medical aid is sought for these disorders, because it is believed that medication will be of no benefit or that the child will outgrow it anyway.

Incidence—It is not incorrect to estimate that approximately twenty per cent of the children develop at one time or another abnormal behavior patterns which last for varying periods of time.

Symptomatology—Mitrano[1] described a train of symptoms of emotional instability arranged in the order of their chronological appearance in children one to fourteen years of age. I quote briefly, as follows: "Sucks fingers, cries when bathed, cries when left alone, fidgets, afraid of strangers, has temper tantrums, afraid of cats and dogs, afraid of the dark, has crying spells, breaks things when angry, slaps other children, has night terrors, has mood swings, is jealous, bites nails, sulks, nervous when hurried, hurts pets, worries, and does not stick to a task."

Etiology—Dysfunction of any organ may alter the behavior of the young. Behavior defects are usually the result of many factors. Some play only a precipitating role. The following circumstances should be considered: poor heredity, alcoholism or lues of parents, trauma to head, a history of encephalitis or chorea, retarded cerebral maturation, hypothyroidism, malnutrition, psychic trauma, environmental maladjustment, refractive abnormalities of the eyes, enlarged adenoids and tonsils, tight prepuce, headache, and other chronic pains.

The role of children's diseases—Measles, whooping cough, attacks of tonsillitis, grippe and other infections may be accompanied, for varying periods of time, by a depression of various physiologic functions. It is noteworthy that fatigue and a low grade or latent fibrositis, which is evidenced by tenderness in the neck, back, abdomen, and other regions, are a frequent aftermath of acute infections. Children who are affected in this way appear to suffer from a chronic malaise which they do not mention and which they are not able to describe. In view of the frequency of infectious diseases among children, it appears likely that in a large percentage of cases the infectious cause plays a major part in the genesis of abnormal behavior patterns.

The role of allergy—Emotional instability is often associated with various manifestations of allergy, such as eczema, asthma, and gastro-intestinal upsets. Shannon[2] demonstrated that high-strung, nervous, unruly, and disagreeable children may be hypersensitive to certain foods. When offending foods were removed from the diet, spoiled and irritable children became happy and friendly. A number of authors have observed relief from nervous symptoms also in adults following the elimination of allergens or following desensitizing treatment. In this connection it is of interest to state that anti-infectious measures may benefit those types of allergy which develop as a sequel of infectious diseases.

TREATMENT

The general health should be built up by rest periods, nourishing diet, Alpine light, outdoor life, vitamins, and syrup of iron iodide. Other causative factors should be corrected. It is especially worth while to search for and treat areas of "silent" fibrosities in the postural muscles. However, it is often difficult and time-consuming to obtain proper response with standard measures.

FOREIGN PROTEIN THERAPY

No reference is found in recent literature regarding the use of foreign protein therapy in behavior defects of children. However, the views held by authorities on the mode of action of foreign protein justify the expectation that it should be helpful in these disorders.

Weichard,[3] a student of foreign protein therapy for more than three decades, wrote as follows:

(a) "The titer of antibodies produced in an animal by repeated injection of a certain antigen can be increased by a multiple by the injection of any protein. This explains why nonspecific measures may have surprising effects in subacute and chronic infections.

(b) "Physiologic functions—for instance, oxidation—can be considerably increased by one nonspecific injection in an optimal dose. Increased oxidation of allergens explains the beneficial effect of foreign protein on allergies."

It is evident that increased cellular oxidation or increased cellular metabolism enhances the functional activity of hypodynamic brain centers and endocrine glands which regulate behavior.

[1] Mitrano, A. J.: Schedule of Emotional Instability, *Am. J. Orthopsychiatry, 9*: April, 1939.

[2] Shannon, W. R.: Neuropathic Manifestations in Infants and Children as a Result of Anaphylactic Reaction to Foods Contained in Their Dietary, *Am. J. Dis. Child.*, 24:89, 1922.

[3] Weichard, W.: Methoden der unspecifischen Therapie, *Klin. Wchnschr.*, No. 27, July 18, 1939.

Tuberculin—The observations of many authors point to its merit as a nonspecific therapeutic agent, by hypodermic injection.

According to Model,[4] tuberculin in proper dosage activates the functions of the thyroid, the adrenals, and the vegetative nervous system if these organs have sufficient capacity for the reaction of stimulation.

Eggston[5] states that he has used tuberculin injections for many years in various eye lesions, and that "it is the foreign protein of choice if the cellular metabolism is to be excited."

Rawson[6] relieved twenty-five patients with distressing fatigue, for which no gross physical or roentgenographic evidence was found, by a course of tuberculin injections.

PERCUTANEOUS TUBERCULIN THERAPY

The term "percutaneous tuberculin therapy" is applied to the introduction of undiluted tuberculin through percutaneous routes for nonspecific therapeutic purposes. The percutaneous route makes use of the immunizing properties of the skin, slows the absorption of the potent antigen, and is believed to modify its toxicity. This method has proved very effective in the hands of many authors.

Lumiere[7] controlled tachycardia, arrhythmia, and dizziness by applying tuberculin through skin scarifications.

Hildebrand[8] observed that "certain nervous disturbances for which no organic lesion can be found often respond to the percutaneous application of tuberculin in an astounding manner."

Loewenstein[9] states that he has used percutaneous tuberculin therapy daily for three years in severe pathologic conditions of the eyes, and has obtained quicker results with this method than with any other treatment. He rubs old tuberculin into a skin area about the size of the palm of the hand after scraping off superficial epidermal layers with sandpaper.

PERCUTANEOUS TUBERCULIN THERAPY IN BEHAVIOR DISORDERS OF CHILDREN

Ponndorf[10] applied tuberculin or a mixture of tuberculin and extracts of streptococci and staphylococci through skin scarifications in a great number of patients. He assumed that toxemia from a latent tuberculosis, sometimes in association with mixed infection, played a role in most chronic disorders, and that his method acted specifically against this cause. Although this theory is untenable, it is conceded that the percutaneous application of tuberculin represents a valuable nonspecific therapeutic measure. Therefore, the favorable response obtained by this author in a large variety of disorders merits our consideration. In his book (p. 21) he states, "I treated pupils, otherwise intelligent, who became so excited in school over their lessons that vomiting set in. This nervous disturbance was soon controlled by a series of vaccinations. Parents and teachers often volunteered the statement that the children became much quieter, steadier, stronger, and capable of prolonged efforts."

Molhant,[11] of Brussels, modified Ponndorf's method by using ektebin, which contains killed tubercle bacilli with a keratolytic substance in an ointment base. It is rubbed into the skin. He states: "Many a time I tried, and with success, to activate cortical functions in children not distinctly backward, but with symptoms of emotional instability, such as impulsiveness, nonchalance, irritability, lack of interest and initiative, and slowness of comprehension. The record cards became better."

OWN OBSERVATIONS

During the past seven years, thirty-two children with various kinds of abnormal behavior have been treated with tuberculin therapy, in accordance with Ponndorf's method. Koch's old tuberculin was used. Twelve children were completely relieved by one treatment. This occurred most frequently when symptoms were of short duration; otherwise, two to five treatments were required. Improvement lasted in most cases from many months to several years. Recurrent cases again responded to similar treatment. Failure was observed in two cases.

Improvement of the following symptoms was reported: nervousness and restlessness, fifteen cases; crying spells, nine; screaming, two; anxiousness, two; bad disposition, six; poor appetite, eight; excessive appetite, one; tiredness, ten; poor sleep, five; bedwetting, two; thumbsucking, two; eating dirt, two; stammering, two. Eight children had defective speech; this symptom responded slowly; in five cases moderate response was obtained; marked response was obtained in two; and in one case there was no improvement.

METHOD OF TREATMENT

After sterilizing the skin with alcohol and drying it, a few drops of old tuberculin are deposited on the outer aspect of the upper arm, and fifteen to twenty scarifications are applied to an area one and one-half inches long and three-fourths inch wide. The scarifications are made with a small scalpel deep enough to go through the epidermis, but not sufficiently deep to draw blood. The tuberculin is rubbed into the scarified area for about a minute. The treated area becomes slightly red,

[4] Model: Mechanism of Tuberculin Reactions, Problemy Tuberculeza, Moscow, No. 7, 1937. Abstracted in *J.A.M.A.*, p. 245, (Jan. 15) 1938.

[5] Eggston, A. A.: Tuberculin in Ophthalmology, *Arch. Ophth.*, **8**:671, (Nov.) 1932.

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[9] Loewenstein, A.: Percutaneous Application of Tuberculin, *Ztschr. f. Augenh.*, (Feb. 14) 1935.

[10] Ponndorf, Wilhelm: *Die Heilung der Tuberculose*, 1923, Verlag F. C. W. Vogel, Leipzig.

[11] Molhant, M.: Function vitale de régulation biologique . . ., *Bruxelles Méd.*, **10**:481, (March 2) 1930.

CASE HISTORIES

Case No.	Sex	Age	History and Complaints	Number of Treatments	Results	Follow-Up
1	F	21 mos.	Eats dirt and sand; very touchy; does not sleep well; rectum prolapses twice a week.	4	Became quiet and less touchy after first treatment. Stopped eating sand. No rectal prolapse after four weeks.	6 yrs.
2	M	5 yrs.	Snuffling without having a cold; nervous; grimaces; grinds teeth during night.	1	Relief of all symptoms in a few days.	1½ yrs.
3	M	10 yrs.	"Always finicky about eating;" headache daily; poor student; nervous; sighs; poor appetite; trace of albumin in urine; under medical care without benefit.	6	Responded gradually; was better in every way with sixth treatment; no albumin.	4 yrs.
4	M	3½ yrs.	Sucks thumb continually; tires and cries easily; bedwetting.	1	No crying spells; less thumbsucking; less bedwetting.	4 yrs.
5	M	5½ yrs.	Underweight; below normal height; touchy; "bad disposition;" poor appetite; cries easily.	1	Improved in every way.	1 yr.
6	M	6 yrs.	Listless; nervous; grades below par; talks fast; pronounces indistinctly; poor appetite; does not mind; pouts and cries.	2	Improvement of all symptoms after first treatment. Talks more distinctly; behaves normally; gained three pounds in four weeks; has better color.	4 mos.
7	M	7 yrs.	Decidedly backward boy; grimaces; nervous; many crying spells, especially in presence of strangers; poor speech; lack of concentration; unfit for school.	2	Easier to handle; no crying spells; no grimacing; less nervous; better concentration; speech improved; not yet in school.	1½ yrs.
8	M	5 yrs.	Below normal in height and weight, tiny up to three and one-half years; stuttered three months; has to sleep until noontime, otherwise he is "fagged out"; no appetite; gets wringing wet every night at midnight; mentally alert; restless; worries about father who is overseas. Treated in Army camps without benefit.	2	Improved in every way; night sweating disappeared; gets up early; better appetite; better color; less irritable; more active.	4 mos.

and the scarified lines become raised and whitish. This reaction lasts one to three hours. Neither local, general, nor focal reactions have been observed or reported. The interval between treatments is three to four weeks. According to Ponndorf, less response is obtained at shorter intervals. However, in children with toxemia, following acute infections, the first few treatments may be given ten days apart. No ill effects resulted from the treatment in any instance.

CONCLUSIONS

1. The rationale of percutaneous tuberculin therapy is presented.

2. Results obtained with this method in thirty-two children with various kinds of abnormal behavior are reviewed.

3. The beneficial effect of the treatment on behavior disorders calls for further study and evaluation of the therapy on a much larger scale.

COMMITTEE INVESTIGATING JAPANESE MEDICAL SCIENCES MAKES FINAL REPORT

The final report of the Committee for the Technical and Scientific Investigation of Japanese Activities in The Medical Sciences has been received by the Army Medical Library, according to a recent announcement.

Established in Manila by the office of the Chief Surgeon, the Committee visited every city of importance in medical education and every first-class medical institution in Japan, during a three-month period.

They were unable to examine and properly evaluate all of the many claims of scientific interest made by the Japanese. Some of these claims were not accepted as factual, but were considered of interest and reported. The material examined included literature and information concerning all sorts of medical activity over the past twenty years.

THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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MARCH, 1946

Editorials

CONFERENCE OF STATE SECRETARIES AND EDITORS

This annual conference was held at the American Medical Association headquarters, in Chicago, on February 8 and 9, with the usual large attendance, practically every state being represented. The first of the two-day session opened with a statement regarding current medical legislation, by J. W. Holloway, Director of the Bureau of Legal Medicine and Legislation. Mr. Holloway gave a rather exhaustive resumé of recent legislation affecting the profession, together with a discussion of pending bills in Congress.

This talk was discussed by Dr. Joseph Lawrence, head of the Washington Office of the Council on Medical Service and Public Relations. The original address and the discussion which followed brought information regarding medical legislation right up to date, proving very informative to both state secretaries and editors.

Dr. F. S. Crockett, chairman of the Committee on Rural Medical Service, of the American Medical Association, discussed the plans being adopted by this committee for the handling of present and future problems. Dr. L. W. Larson, Secretary of the North Dakota State Medical Association, opened the discussion of this paper.

Luncheon was served in the A.M.A. building, after which the program for the day was resumed, with General George F. Lull, former Deputy Surgeon General of the United States Army—and soon to become assistant secretary and general manager of the American Medical Association—spoke on "State Plans for Aid to Returning Medical Veterans." Victor Johnson, Secretary of the Council on Medical Education and Hospitals, and Robert C. Ayres, Director of War Property Distribution of the Federal Security Administration, discussed General Lull's talk.

"Plans for Furnishing Medical Care to Veterans" was discussed by Colonel James C. Harding, of the Veterans Administration. The discussion was opened by Dr. L. Fernald Foster, Secretary of the Michigan State Medical Society.

The annual Editors' Dinner was held in the Palmer House, that evening, with a very large attendance. A large number of the "gentler sex" were present at the dinner, as were a large group of non-editors. However, the editors took over the meeting, and with Dr. Lyman W. Mason, Editor of the *Rocky Mountain Medical Journal*, presiding, proceeded with the regular program. Dr. Henry A. Davidson, Editor of the *New Jersey Medical Journal*, conducted a "clinic" on editorial problems. He presented the problem and called for a discussion by the editors present. Among the problems presented were: "What about letters to the editor—how are they handled by your Journal?" "What about editorials—do you believe they should be confined to scientific subjects, or should they refer to economic problems of the profession?" For more than an hour these and other questions were informally discussed by the editors, with much profit.

The Advisory Committee to the Cooperative Medical Advertising Bureau then asked for time to present "The Operative Principles for the Cooperative Medical Advertising Bureau," which had been under consideration of the committee for some time, and on which they had spent the greater part of the previous day. After some discussion it was unanimously voted that these principles be given the official approval of the group, and that they be sent to the Board of Trustees of the American Medical Association for its approval, and later be acted upon by the Councils of the component participants.

This annual conference has become of great import, since it affords an opportunity for the state secretaries and editors to get together, to air their views on medical economic problems.

Some changes have been made during the past year in both state secretaries and medical editors, and the newcomers into the meeting were given a hearty welcome by the oldsters. The writer had attended fifteen such conferences and over the years has noted a marked improvement in the

character of the programs and in the interest displayed by all in attendance. Several amusing and entertaining episodes came about during the meeting, Holman Taylor, the Old Texas War Horse, as usual providing many laughter-provoking incidents. In passing, it might be mentioned that after some thirty-five years Dr. Taylor now has an understudy, Dr. R. B. Anderson, of Fort Worth, who has been on the job for a few years. It is remarkable to us how quickly Dr. Anderson has become a second Holman Taylor; he talks just like Holman does—perhaps not as much; has adopted all of Taylor's mannerisms, and thinks along the same channels; it is safe to say that Texas will continue to be well represented in these conferences, even after Holman decides to retire.

The second day of the conference a half-day session opened with a discussion of "Public Relations and American Medicine," by Morris Fishbein, the leader in this discussion being John Hunton, Executive Secretary of the California State Medical Association.

The official program closed with the presentation of a paper by Jay Ketchum, Executive Vice-President of the Michigan Medical Service, who talked on a national medical pre-payment plan, followed by a discussion by Dr. Edward J. McCormick, chairman, and A. W. Adson, member of the Council on Medical Service and Public Relations.

INDIANA'S HEALTH PROBLEMS

Governor Ralph Gates, in his guest-speaker address at the annual dinner of the Indiana State Medical Association, held at French Lick last November, electrified his audience with his comments on Indiana health matters. He showed an amazing knowledge of health conditions in our state; likewise an amazing knowledge of how the problem could be—must be—solved. His audience wondered just where he had acquired all this information.

The answer to this is the published data regarding health conditions in the various states of the Union. These figures for Indiana are not so favorable. In the first place they reveal that there are only four states that have been spending less per capita for health measures than Indiana; and that the death rate in Indiana is near the top!

Thus, the recently-reorganized Indiana State Board of Health and the new Public Health Advisory Council start their program, knowing just what is ahead of them. They know the figures quoted; they know full well that Indiana must be up and going if we are to improve our health standing among the states.

The Board and the Council are also faced with the fact that in the entire state there are but *four* full-time health departments! This alone would be a good starting point. Present-day health authorities are united in their belief that full-time health officer service is *sine qua non*, and that while remedial measures may be taken here and there, a well-directed health program can be successfully undertaken only when we have fully-qualified medical men in charge of such programs.

Dr. L. E. Burney, Director of the Indiana State Board of Health, and a man in whom we have the utmost confidence, makes the declaration that there should be at least thirty-three full-time health departments in Indiana. We are quite willing to accept Dr. Burney's opinion in that regard. Further, the case of South Bend furnishes an example of what is being done in health matters, and what might be done with a full-time, non-political health officer in charge. One has but to read a recent report of their highly-efficient health officer, Dr. F. R. N. Carter; he is doing excellent work, but has many limitations that would not be had were this a full-time department. The same situation applies over the state, generally.

In Indiana, the per capita expenditure for public health is *thirty cents;* in Michigan, for the same period, it was *three dollars!* For the past six years our annual death rate had been eleven per 1,000 population. Most of the other states show an annual decrease in its death rate. This, added to the fact that our death rate continues to be higher than the national figure, gives us something to think about.

We now have an ideal setup so far as our state organization goes; we have a revamped State Board of Health, with a man at its head who already has proved his worth to the state; we have the new Health Council, which given time to get going, will prove of inestimable help to the State Board. And, in addition, we have a health-minded Governor, a man who recently stated that public health is one of the commodities that can be purchased! We never had heard that expression, but it strikes us as being "mighty forceful."

We have an abiding faith in our great Hoosier state and its people, and are of the opinion that once they learn of the true state of Indiana's health they will demand that corrective measures be undertaken. In our long years of medical experience, we never have heard any objection to spending money for improving public health, and do not believe that there will be any serious objection to such expenditure in this case.

This whole matter ties in with the better medical education program which is discussed in an adjoining editorial, and the solution of both problems can be worked out at the same time. This calls for a practical program on the part of Hoosier Medicine; we must lend every aid in bringing Indiana Public Health up to the top. It can be done, and, according to our Governor, it will be done!

BRUCELLOSIS

For some time past THE JOURNAL has commented on the subject of a disease that long has been with us, yet until recent years had not attracted the attention it merits—that is, brucellosis. Many other journals have taken part in the campaign to interest members of the profession in this important subject; while several state associations, at their annual meetings, have held symposia on this subject.

Brucellosis remains unrecognized in many instances, when as a matter of fact a simple agglutination test would serve to alert the practitioner as to what may be ailing his patient.

In an article by Carryer and Prickman, published in the *Proceedings of the Staff Meeting of the Mayo Clinic*, for January 9, brucellosis received an unusual amount of attention, the article being headed "Brucellosis and Pepic Ulcer." The authors go into the history of the disease, stating that "undulant fever is not a disease of recent origin," saying that Hippocrates described an illness with fever lasting as long as one hundred days, which the authors indicate, "may have been undulant fever."

The infection is believed to have had its origin on the Island of Malta, 'way back at the time of the Crimean War, and to have come from goat's milk. In 1887, Bruce, an Army surgeon, discovered the germ in the spleen of soldiers who had died from the infection, and from him we have the name, "Brucellosis." The British Army then undertook a survey of the matter and found in the serum of goats "a high titer of agglutinins affecting this organism."

Then, along in 1897, Bangs, of Denmark, described a bacterium in the uterine discharge of cows which had aborted, this disease then being named "Bang's Disease"; later it was found to be the same as brucellosis, undulant fever, Malta fever, or what have you.

The authors then state that "it now has become clear that there are three main and closely related types of bacteria in the group causing undulant fever." As we frequently have stated, the transmission of this disease is primarily from contact with milk and milk products, cattle and hogs. It also has been demonstrated that the disease is much more prevalent in country districts than in the urban centers, this because in the latter pasteurized milk is more commonly used. Another reason is that milk sold in cities usually comes from dairies that are subject to frequent, rigid inspections, and cows infected with Bang's disease are eliminated from these herds. The incidence of the disease, it is noted, is considerably less among children than in adults, and men are more prone to the infection than women.

This article adds to our contention that brucellosis is much more common than suspected and that in many Indiana areas it may be said to be almost endemic. As we have said, the disease can be relatively easily diagnosed via the agglutination test. We urge the members of the profession, particularly those located in the rural sections, to be on the alert, especially in cases where there is long-continued fever associated with pains of an "indefinite" type.

Further, since the cause of the disease is well known and the remedy lies in the elimination of infected cows from the herds which supply our milk, it would seem that our health authorities might well become interested in a state-wide elimination of brucellosis.

"FULL FOUR YEARS AT INDIANAPOLIS"

THE JOURNAL recently came out in favor of the transfer of the "First Year" from Bloomington to Indianapolis, advocating its being brought to the campus of the Indiana University Medical Center. This was the result of many conferences, not only with medical men in Indiana and with students in our medical school, but with those concerned with medical education in our state. An additional spur was the address of Governor Gates, at the French Lick session of the Indiana State Medical Association.

The Governor stated in strongest terms that we had to have more and better doctors, and that better doctors could be had only by better medical education. And, quoting the Governor, "better medical education involves the spending of money; we cannot have better education of any sort without paying an added cost." While these are not the exact words of Governor Gates, they express his ideas on the subject.

As we view it, one of the greatest advantages of bringing the freshman medical years to the Indianapolis Medical Center is the happy effect on the freshmen students themselves. They would from the beginning be in a medical atmosphere; they would have daily contacts with medical men who are in active practice; they would be in daily association with medical students of the upper classes, and such contacts cannot help but be of benefit. In other words, freshman medical students become a part and parcel of our medical education system right from the beginning.

Such a change would, of course, necessitate some new buildings, among other things, but this is not an unsurmountable barrier. The state administration has spoken on this subject and has made it perfectly clear that better doctors and better medical education are two of the *musts* in the new plan.

Since the publication of the editorial a few months ago, in which the plan was first publicly advocated, we have had many favorable comments, and practically no objections have been registered with us. We believe that those who are intimate

with the matter are in full accord with the plan, and we feel that Governor Gates highly approves of any measure that will bring about better medical education; hence there seems but one thing to do—go out and get what we are asking for!

We must build up for this, and our suggestion is that this building-up process begin with the county medical groups. If there are a large percentage of these groups in favor of the movement it is certain that the state association will back them up. As we view it, our Committee on Medical Education has a job cut out for it; this committee has done excellent work in laying out the groundwork for the plan, and we believe that this is the time for concerted action. If we all get behind the movement it cannot fail.

Editorial Notes

The Fort Wayne Lions Club is sponsoring a drive to make the cancer project a state-wide affair, according to the *Avilla* (Indiana) *News*. It seeks to establish a cancer center somewhere in the state, equipping it with every modern facility for the study and treatment of this disease. Just another evidence that the general public is becoming "cancer-conscious."

After more than three years' work, the Advisory Committee to the Cooperative Medical Advertising Bureau has formed what is believed to be a workable plan for the future. This plan will be submitted to the official body of each of the state medical organizations handling such matters, for its approval. A fuller statement of what this is all about will be the subject of an editorial in a later number of THE JOURNAL, since it is a matter that should be of much interest to all members.

It is probable that the 1947 General Assembly will be asked to appropriate a considerable sum for the purpose of erecting two new state hospitals, one for the insane, and the other for crippled children. Both plans were before the 1945 session, but no definite appropriation was made, due to the fact that the plans had not fully been completed. It is reported that the insane hospital, to be located in the northern section of the state, will also house the criminal insane from the five other state hospitals.

The *Corydon Republican* published the most concise criticism of the attempt to foist socialized medicine on an unsuspecting public we have yet seen; it is short and to the point: "Our understanding is that this socialized medical health insurance plan is designed to force the guy at the next desk or the next lathe, who has a sound appendix, to help you pay for your operation." There is a lot of red meat in those few words!

The Journal of the American Medical Association, of January 5, states that DDT, in pure form, is harmless to man, but that the deleterious effects so often recorded from the use of the various products containing this preparation are due to some of the solvents used in marketing the preparation. For example, it is stated that skin irritation following the use of a 5 per cent DDT-kerosene spray is due to the kerosene and not to the DDT itself.

The *Franklin Star* recently paid a most deserved tribute to three medical men from Edinburg, who had died in the last ten months. The average period of service of these three men in that community was thirty years. The editorial comment, under the head, "Non-Uniformed Veterans," gave due credit to these men for their activity during the war years, at a time when most of them had planned at least a semi-retirement, but due to the demands of wartime they carried on just as long as they were able so to do. Throughout the entire state we have many such examples of men who were at or past the retirement age, but who carried on, day and night and in all sorts of weather, doing their bit as they saw it. They are the unsung heroes of World War II.

Comes now a well-authenticated tale about an experience in one of the store houses of the War Property Disposal Agency. It seems that a large crate marked "dishes" was received, and that the head of the local department ordered the box to be opened, that he might see just what sort of dishes were contained therein. Much to the surprise of everybody concerned, it was found that the box contained garden rakes, with the handles sawed in two! Official inquiry was begun, and as nearly as could be determined it was found that some G. I. had been ordered to pack the rakes into the box, and finding this impossible because of the long handles, had done the only possible thing—sawed the handles in two, thus completing the job, according to "orders."

With the Atomic Bomb still a favorite subject for discussion, with electronics, television, and such truck also occupying the attention of most of us, it is not at all surprising that new fake "remedies" continue to crop up. The latest to come to our attention is reported from a northern Indiana city, where three persons were being held in connection with a scheme to mulct the gullibles of that area. These folks were charged with selling, at three hundred dollars per copy, a small glass tube which was claimed to have radio-active power. As a curative agent, it was claimed to control such ailments as high blood pressure, diabetes, gangrene, et cetera. About the next thing we will hear of will be an "atomic capsule" that will be the final panacea for all the ills of mankind, and when this comes along, it will be sold at a price never heretofore attempted by such promoters.

Under the direction of Dr. A. S. Giordano, of South Bend, the St. Joseph County Medical Society has evolved a plan for medical care of veterans, which has been submitted to the Veterans Administration, and which impresses us as being tops. Briefly, the plan provides for the care of service-connected disabilities, by local physicians; the treatment to be administered at home rather than sending the patient to a government hospital. The veteran chooses his own physician in all instances and the inconvenience of going to some distant point, there to be hospitalized, is avoided in most cases. Such a plan would be not only a convenience to many veterans, but being treated at home would do much to relieve overcrowded conditions in veterans hospitals, making room for the more serious cases. The *South Bend Tribune* strongly recommends the proposal.

Evidently our editorial comments are read, at least occasionally, by some of our down-state papers, for quite frequently they take occasion to comment on something we have talked about. In a recent issue of the *Indianapolis News* the editor commented on one of our "Indiana Tomato Boosts," evidently being in accord with what we had to say in the matter. We still believe that Indiana produces the finest, best-flavored tomatoes in all the land, a belief bolstered by the fact that of late we have personally tried out the tomato juice produced in at least a dozen other states, and have come right back to the Hoosier State for its tomato juice, which is simply "tops." We even tried it on the youngest of our grandsons, not yet two years old. As I came in this evening, Mom said, "Dad, what do you know? Stevie drank *three* glasses of that new can of tomato juice you opened this morning!" (And that juice came right fresh from my old home town, down near Wild Cat!)

Much concern is being expressed in many sections of the country regarding the increasing sale and use of preparations containing the barbiturates. It appears that many states exercise little or no control over these products; hence, they are available to the public at many drug counters. Here in Indiana this is not so much of a problem, since druggists are not permitted to make such sales without the prescription of a physician. Physicians frequently hear their patients comment on the fact that they have been using barbiturates "on their own," and that these are readily obtainable at most pharmacists—save in a few states—without let or hindrance. Much of this problem may well be laid at the door of the medical profession. A patient phones his doctor, saying he is unable to sleep; then the physician replies, "Go over to the drug store and get a few tablets of '———.'" This the patient does, and the next time he has a bit of insomnia he does not call the doctor, but again goes to the druggist. In our opinion the barbiturates need regulating, just as do the other narcotics.

In speaking of the housing shortage, we recently mentioned that Montezuma was without a physician, and that local authorities were making strenuous endeavor to remedy the situation. It seems that one or two physicians wished to locate there, but could find no living accommodations. According to recent press reports the local authorities have planned to purchase a residence and rent it to some physicians who will locate there.

Press comments are to the effect that there has recently been a marked increase in the number of victims of wood alcohol; not a few of these being returned service men. In a recent number of *The Journal of the American Medical Association* a group of Navy physicians reported a series of thirty-one such cases. It reminds us of the Volstead era, when many physicians were called upon to treat such cases, many of which resulted in blindness.

Dr. C. L. Williams, of Logansport, has been appointed director of the new Indiana Mental Health Council, by Governor Gates. Other physicians on the council are Dr. E. Rogers Smith, Dr. Norman Beatty, and Dr. Leroy E. Burney, all of Indianapolis. The duties of this council are to supervise the treatment of mental patients in public institutions, and to exercise jurisdiction over licensing and standards for private institutions for the care of mental cases. The building of a new mental health hospital on the Indiana University Medical Center campus is also under the jurisdiction of this council.

In an address to the Indiana Veterinary Medical Association, Dr. Leroy E. Burney, Director of the Indiana State Board of Health, made several recommendations, all of which are of much merit. Chief of these is the suggestion that all packing companies, whether they prepare meats or poultry for the market, should be under the supervision of the Indiana State Board of Health. The carrying out of such a plan, to cover the entire state with its more than two hundred fifty packing establishments and slaughter houses, would require the service of some one hundred Doctors of Veterinary Medicine. While this seems to be a huge undertaking, yet it is one of vital import to our future health program. As it is today, few such institutions are regularly inspected—none save those that come under the direction of the Federal Government—and while it probably is true that most Hoosier packing houses observe health regulations, there are some that would be very much improved with regulations. Federally-inspected meats have come to be well known to householders, many of whom look for the "stamp" when making such purchases. A Hoosier branding of locally-slaughtered meats would soon be well understood by most folk, and we trust that the suggestion of Doctor Burney in this regard may be carried out at an early date.

"Socialize Everything or Nothing" is the heading of an editorial which appeared in the *New York State Journal of Medicine* of December 1, 1945, and which gives us something to think about; hence, it is reprinted for the benefit of our members as well.

SOCIALIZE EVERYTHING OR NOTHING

"Yes, the war is over and everything is lovely now. You can relax. Especially if you are a physician. Everything is going to be 'duck soup.' The young men are coming back. The War Bonds you have bought are going to be a solace in your old age. Penicillin, streptomycin, and the sulfa drugs will reduce the practice of medicine to a mere routine, eliminating the necessity for diagnosis, and anything else can be sprayed with D.D.T. except a few surgical cases, useful for teaching purposes. The postwar world should be something! Ho, hum! So they are going to nationalize the Atomic Bomb and pay higher wages for shorter hours of work and reduce taxes. Splendid; no doubt about it. Splendid!

"Those fellows down in Washington are pretty smart. Look how they fed everybody during the war and gave them all that gasoline, tires, and oil; meat and cigarettes, too. Maybe they could do as good a job with doctoring the folks now that modern science has made it so simple and all. Something to think about! Especially for poor people. There are getting to be so many poor people now, with the cost of living going up so fast, and the take-home money getting less and less. It doesn't seem right, somehow. Maybe that's why there are so many strikes.

"Well, it will all be better as soon as the Wagner-Murray-Dingell Bill, 1945 version, is passed. That bill will 'socialize' medicine for the poor folks—and the rich ones, too—and give them ever-loving government medicine with employers paying 4 per cent on wages up to $3,600, the same as they pay now for unemployment and old-age benefits on wages up to $3,000.

"Of course, the employees would be taxed 4 per cent on wages up to $3,600 a year, *about four times what they pay now on wages up to $3,000 a year,* but who minds that? Certainly not the employers. Unless they happen to employ themselves. For making *that* mistake they would pay 5 per cent and be ineligible for unemployment and temporary disability insurance—and serves them right, too; let them get sick and see who cares.

"If you are foolish enough to work for yourself, the worst is too good for you.

"But we will skip over all these tiresome figures. Everybody knows that if you want security you have to pay for it. Take the recent war, for instance; well, it gave us security, not particularly social perhaps, but security for a while from dictators—except in Argentina and Spain—and we will have to pay for that somehow as well as the 'socialized' medicine and the strikes which don't produce any salable goods, to our way of thinking, so why don't we socialize everything and be done with it? Messing around with a partly free and partly socialized economy seems to us to combine the worst and most expensive features of each, to no particular advantage.

"As we have hinted at various times, we are opposed to the socialization of medicine, but if the public must have it and is willing to pay for it, then we demand the socialization of everything—whole hog or none."

Never in the history of medicine has neurophychiatry made such tremendous progress as during World War II, when sixty per cent of the soldiers with combat-induced mental illness were returned to combat duty following neuropsychiatric treatment. A recent issue of *War Medicine*, published by the American Medical Association, gave an over-all picture of accomplishments of the Army psychiatrists, and which is of such significance that we are taking the liberty of reprinting it in part:

"Army psychiatrists who specialize in maintaining the mental health of millions of American boys in service succeeded in returning 60 per cent of the troops with neuropsychiatric disorders to further combat duty, according to *War Medicine*, which is published by the American Medical Association. An additional 30 per cent were salvaged for noncombat duty in the European theatre of war. Of the remaining 10 per cent who were evacuated to this country, approximately 40 to 50 per cent were salvaged for further Army service. The remainder were discharged.

"These figures, said Brigadier General William C. Menninger, of Washington, are 'evidence of reasonably effective hospital management and treatment.' General Menninger is director of the Neuropsychiatry Consultants Division, Office of the Surgeon General, Medical Corps, Army of the United States.

"It is not uncommon in a large Army camp for psychiatrists to have five hundred consultations a month.

" 'This high referral rate,' wrote General Menninger, 'may be related to the structure of the Army, which requires every man to be a follower and many to be leaders. When a man fails in either of these roles, he may become a "case." Certainly GI Joe cannot choose a different leader; usually he cannot change his job. When a leader fails in his responsibility, his methods may increase the possibility of maladjustment among his men. When a follower fails to accept his role, his behavior may increase the maladjustment of others in his unit.'

"General Menninger said that at the present time there are approximately eighteen hundred medical officers assigned to psychiatry. Of this number, approximately seven hundred had some type of psychiatric experience before their military service, and the remainder have received their psychiatric experience or training in the Army. In addition, the Women's Army Corps recruited about four hundred for Army psychiatric work.

" 'Even with all these additions,' General Menninger wrote, 'there continues a shortage of psychiatric personnel, which is equally true of several of the other specialists groups within the Medical Department.' Continuing, he said: 'Special pride can be taken in the methods of treatment used in combat areas and their results. Unfortunately, before actual combat in 1942 there was no definite plan established for the treatment of neuropsychiatric casualties. It was assumed that they would be taken care of in general hospitals. Immediately after the American forces engaged in combat in the Mediterranean theatre, it was found that not more than five per cent of such casualties were returned from the general hospitals to combat duty. As a consequence, improvised measures were created in the forward areas to provide early and immediate treatment.'

"That the general plan of treatment in each of the armies brought results is seen from the fact that 60 per cent of the soldiers with combat-induced illnesses were returned to combat after treatment.

" 'Neuropsychiatry has made tremendous strides, not only in its wider application but in the specific technics used in the Army,' said General Menninger. 'No one closely connected with it fails to recognize the many inadequacies which are still apparent. With the responsibility merely to provide treatment for combat-induced mental illnesses, the job would be big, but with ramifications into selection, motivation, prevention, screening, and evacuation, as well as the problem presented by the maladjusted soldier who has never seen combat, the psychiatric job assumes colossal proportions.

" 'The war has brought to greater attention the fact that there are many persons with poor and with borderline adjustments in the cross-section of the male population of military age who are incapable of combat duty. Such men, when inducted, throw a tremendous additional burden on the Army; they are usually referred to the Medical Department, and a large proportion of them must be evacuated psychiatrically. This responsibility exacts a considerable portion of the time of many military psychiatrists.' "

President's Page

The much-discussed Prepayment Insurance Plan has finally been adopted. The details are published in the Minutes of the House of Delegates in this issue of THE JOURNAL. This office has been deluged with questions and criticism since the last meeting of the House of Delegates on the happenings that followed. I assure you that there was no intention by anyone to be underhanded or dishonest. But when mandates are put up to the duly-elected presiding officer, he feels that he must act accordingly, regardless of his own opinion. And, as for criticism—we welcome it, because then we know that you are interested in the welfare of the association as a whole, and we are thus better able to avoid such situations in the future. After all, we are all working for the good of organized medicine and must keep personal animosities at a minimum, for, as has been stated in this page time and time again, medicine as we know it is now in a very critical state of health. And to survive the disease—Socialized Medicine—every general and special practitioner in the association must put forth every effort to save the patient.

We have devoted much of our attention to the above situation, but we must not forget that there are also other problems confronting us. One of the most important is the situation in regard to the veterans of World Wars I and II. The housing situation for returning veterans and their families is a national problem, and should be handled as such, but the health of these men is another problem, and it is up to the medical profession to see that this is cared for. It is very gratifying to learn of the number of state associations that have set up such a service and are working whole-heartedly with the Veterans Administration, and now our own state association should come through with some type of an organization under which we can all perform our duty toward veterans with service-connected disabilities. Urgent need for assistance by civilian doctors has developed because the Veterans Administration does not have sufficient medical personnel.

It is very important that the Committee on the Certification of the General Practice of Medicine, in the State of Indiana, function well. The preliminary work has been done, and we all hope that it will be a going concern in a short time. I am sure that all of you feel the same way about it as I do; that this is an epoch in the progress of Indiana Medicine. Those of us who have worked toward this end can feel that there will be handed down to posterity an inducement to do better work in every line of the noble art of the Practice of Medicine.

I believe that all the agitation in regard to better medical care has been a godsend to us. For one thing, it has awakened us from a certain type of complacency, and has caused us to take an inventory of just how lethargic we have been in our imagined security—thinking that no one would have the nerve to awaken us from our Rip Van Winkle sleep or try to interfere in such a noble profession. But alas, such is not the case—reality is upon us, and we are now working like a little bee whose home has been destroyed by some big monster. In our hurried efforts to rebuild, let us build on a more firm foundation, keeping in mind that our profession is only a cog in a fast-moving world which is growing so rapidly that if wise control is not exerted over some of the elements of this fantastic cinema, destruction of the whole universe is inevitable, reverting back to—who knows—possibly the re-establishment of a new civilization that would have to come from a one-cell organism in millions of years to come.

J. E. Farrell

TUBERCULOSIS CASE FINDING IN MARION COUNTY HIGH SCHOOLS

WARREN S. TUCKER, M.D.

INDIANAPOLIS

The program of tuberculosis case finding in the Marion County (Indiana) high schools was instituted by the Marion County Tuberculosis Association with the approval of the county medical society.

The purpose of the program was three-fold:

1. To discover all active cases of tuberculosis and, wherever possible, the contacts.

2. To determine the incidence of infection.

3. To educate the students and families concerning tuberculosis.

Preceding the 1944-45 school year the procedure was to tuberculin test the students with 0.1 mgm. of old tuberculin in 0.1 cc. solution and x-ray the positive reactors on 14 x 17 film. During the 1944-45 year the students were x-rayed with 35 mm. film and the suspicious cases re-rayed with the 14 x 17 film.

After educational talks were given to the student body, the testing was offered to the junior students. They were required to bring written consent from their parents. The cafeteria helpers in some of the schools were also tested.

The time for the testing was arranged with the school principal in order to cause the least amount of confusion.

Although different physicians tested the Crispus Attucks (Negro) High School and the other schools, an attempt was made to follow a set standard. All tests were read as positive or negative, and those that were doubtful were read as positive.

In the smaller groups tested only two nurses and one doctor were required to do the work. One of the nurses filled the syringe with 0.1 cc. of old tuberculin, and the other, with the help of the students, cleansed with green soap and alcohol the posterolateral aspect of the upper arm of the student to be tested. In the larger groups another doctor and nurse were needed. In this way each team could easily test six students per minute, and when necessary ten per minute could be done. The reading of all the tests forty-eight hours later was done by the same doctor for uniform reading, and could be done in about the time necessary for the students to line up and pass by.

After all schools had been tested a mobile x-ray unit was taken to the schools and a 14 x 17 x-ray made of all the positive reactors. The films were then interpreted by radiologists of Indianapolis, and the reports were sent to the doctor whom the student had designated to receive the report. Attempt was then made with the help of the family doctor to find the open case that had been the original contact. This proved to be the weakest link in the program, as some families were indifferent, and even some of the doctors told the families that the whole procedure meant nothing and was a waste of time. However, the majority of the families where active tuberculosis was found in the student were quite anxious to find the original source of the infection. The proved active cases were removed from school.

The findings from the x-rays were not limited to tuberculosis. Other chest pathology shown on the films was reported to the family doctor. This included heart abnormalities as well as bone malformations, suspected bronchiectasis, emphysema, and the like.

A chart of the findings is appended to this report. A brief summary shows that in the eight years from 1937 to 1944 the average per cent of positive reactors was 34.23 per cent and for the last four years averaged 31.25 per cent. From this number of positive reactors were found, by x-ray alone, 82 active cases of tuberculosis and 117 questionable cases which needed further study for a correct diagnosis. Also during this time 8 active and 22 questionable cases were found in adults who worked around these children, and only a small percentage of these workers were tested.

A check of the figures shows that not all of the positive reactors reported for x-rays due to sickness, indifference, or change of residence to another community. However, an endeavor was made by the nurses to have these students x-rayed at another school if they missed the x-ray at their own.

This program has been an aid in educating the public, as shown by the fact that during these eight years fifteen-thousand parents or near relatives of the positive reactors were instructed in groups about the meaning of the positive Mantoux test and the seriousness of the tuberculosis problem. It is known that these people are absorbing at least some of the information because these conferences are better attended and receive more interest than any similar programs carried on in the schools.

The approximate cost of this program in 1943-44 was $2,497.48, and the cost per student x-rayed was $1.90 each, exclusive of the salaries of the Tuberculosis Association nurses. The funds were made possible from the Christmas Seal sales.

The costs of the program may seem excessive. However, when it is considered that it costs between $10,000 to $15,000 to cure an advanced case of tuberculosis, $1.90 is a small sum to pay in order to find the suspects, early cases, and those who are infected with the germs, and who can thus be advised so that they may never have the active disease.

In the 1944-45 school year when the program was changed to group x-raying with the 35 mm. film, 3,990 students and 274 adults were x-rayed, with the following results:

TUBERCULIN-TESTING AND X-RAYING

High Schools (Public, Parochial, Rural)—Indianapolis, Indiana—
by the Marion County Tuberculosis Association

YEAR	NUMBER TESTED	POSITIVES	PER CENT POSITIVE	NUMBER X-RAYED		FINDINGS						OTHER CHEST PATHOLOGY	
						ACTIVE		QUESTIONABLE		HEART			
	Students	Students	Students	Students	Adults	Students	Adults	Students	Adults	Students	Adults	Students	Adults
1937	1,195	473	39.58	452	.....	4	....	30	....	.....	....	.....	....
	(Crispus Attucks only)												
1938	5,343	1,747	32.69	1,645	191	30	....	33	....	104	....	187	....
1939	2,775	805	29.36	796	85	14	....	....	....	31	....	28	....
1940	2,366	1,117	47.21	1,079	175	8	....	....	....	61	....	115	....
1941	5,004	1,536	31.14	1,495	190	13	....	6	....	29	....	52	....
1942	5,503	1,786	32.45	1,786	131	8	5	18	8	28	4	32	2
1943	4,592	1,393	30.33	1,336	179	4	1	14	2	50	9	44	6
1944	3,755	1,168	31.10	1,186	117	1	2	16	12	14	15	47	13
Total	30,533	10,025	Avg. 34.23	9,775	1,068	82	8	117	22	317	28	505	21

Students: Three active cases who are now under treatment.

Seven questionable cases who are under medical supervision.

Adults: No tuberculosis found.

Comparison of the two types of programs will be made after a comparable period has been covered.

SUMMARY

1. Tuberculin skin testing and x-raying of junior students in Marion County High Schools during eight years are reported.
2. An average of 34.23 per cent were positive reactors to the Mantoux test.
3. Eighty-two active and 117 questionable cases of tuberculosis were found by x-ray in these students.
4. The program has proved of value in the education of the public, as shown by the decline in the incidence of disease.
5. Although headway has been made in education concerning tuberculosis, there is still too great indifference to the disease by the laity, and a more deplorable indifference by the medical profession itself.

Many physicians, including colored doctors, in Marion County participated in this study, and grateful appreciation is extended for their valuable contribution, without which the work would not have been possible.

414 HUME MANSUR BUILDING,
INDIANAPOLIS.

PREPAYMENT MEDICAL CARE PLANS

Indiana's plan for Prepayment Medical Care is carried in the Minutes of the House of Delegates, published in this issue of THE JOURNAL; and the American Medical Association's program for Prepayment Medical Care is published in *The Journal of the American Medical Association*.

Physicians should refer to pages 153 inclusive of 158 for the Indiana plan; and to page 494 of the February 23, 1946, issue of *The Journal of the American Medical Association* in order to become familiar with the national plan.

THE SECTION ON GENERAL PRACTICE, AS SET UP BY THE INDIANA STATE MEDICAL ASSOCIATION*

O. E. WILSON, M.D.

ELKHART

Almost a century ago the Indiana State Medical Association was founded by physicians in general practice. With the passing of the years there has been an increasing trend toward specialization in our medical schools, our hospitals, and our own scientific meetings. The pleas of the general practitioners have finally been heeded, and a Section on General Practice is being pioneered by the Indiana State Medical Association. It is the desire of the officers of this section to set a pattern for improving the training of the general practitioner and providing the public with better medical care. We are guided by the policy of American Medicine of providing the highest type medical care to the greatest number of people.

In recent years the proponents for schemes for socialized medicine have charged incompetency against the general practitioner as one of the arguments for their schemes. We believe that the section devoted to the general practice of medicine, by stimulating the man in general practice to improve himself further, should go far in discounting these generally false accusations.

In setting out to establish a logical program to accomplish the better training of the general practitioner and to make the general practice of medicine more attractive to the younger men, there are two objectives to be attained. The first objective is to establish some basis of standardization by which the physician can measure his own qualifications and determine his shortcomings. This was initiated at the meeting of the House of Delegates of the Indiana State Medical Association, held at French Lick, on November 6, 1945, where a resolution was passed authorizing the President of the Indiana State Medical Association to appoint a committee of fifteen members from over the state, including a member of the faculty of the Indiana University School of Medicine, to formulate plans for the certification of general practitioners.

This committee should be appointed as early as possible and should be composed of active men of good sense and judgment. Their responsibility is to set up standards for training of future general practitioners and to outline requirements for certification by the Board of General Practice. For a more comprehensive outline of one set of proposals I call your attention to the report read by Dr. Gordon Thomas at the recent meeting of the House of Delegates, and published on pages 555 and 556, of the December, 1945, issue of THE JOURNAL of the Indiana State Medical Association.

Some of you may ask, "Why all this furor? What is the value of such certification?" It would serve in two ways: first, to stimulate the physician in general practice to inventory his own capabilities, and by self-study and attendance at clinics to better train himself; and second, by serving to add glamour to general practice, for it indicates that you have been tried and not found wanting.

Such a board should review the present courses and methods of teaching in our medical school and hospitals, to insure the student the best possible training. The student should be oriented as to the art of medical practice.

The second objective is to provide means for the physician in general practice to get more out of clinics and scientific meetings.

This I believe can be accomplished by impressing upon speakers at our various meetings of the necessity of planning their subjects for the general practitioner. Too often in the past these meetings have seemingly served only for the aggrandizement of the specialist giving the paper. It was his way of advertising for our business. In our county medical society meetings this should be kept in mind in the planning of our programs.

In our Councilor District meetings the emphasis should likewise be placed on programs keyed to the needs of the general practitioner.

We believe that there should be at least one issue yearly of THE JOURNAL of the Indiana State Medical Association designated as a General Practice Number. If possible, we would like to have a section of each issue devoted entirely to general practice, with special articles for the general practitioner concerning diagnosis, treatment, et cetera.

Perhaps it would be possible to work out a series of short, intensive clinics at the medical school for the benefit of the general practitioner desiring to brush up on some particular subject, the clinic to be of one week's duration.

Undoubtedly each one of you have your own ideas of what this section should be like. It is the earnest desire of the officers to have your views and suggestions. We want every county secretary to sound out the membership in his own county and let us know his wishes. They will be utilized wherever possible.

Before concluding I want to point out and clarify this one point regarding certification of general practitioners. The certificate granted would not of itself confer upon any person any degree or legal qualification, privilege, or license. It would not in any way interfere with the professional

* Presented before the Secretaries' Conference of the Indiana State Medical Association, at Indianapolis, on January 13, 1946.

activities of any duly-licensed physician. It would merely indicate that the physician holding such certificate had demonstrated, by passing the required examinations, that he had a well-rounded training qualifying him for the practice of general medicine. A physician not holding such certificate would still be a general practitioner and would be so called. He would not and should not be discriminated against, belittled, nor looked down upon by those holding certificates.

Your officers of the Section on General Practice, Dr. Oliphant, Dr. Black, and myself, have as our objective the making of this Section on General Practice the most important in our state organization. We can do this only with the full cooperation of every general practitioner. We earnestly request each of you here, as well as each general practitioner throughout the state, to give us their suggestions and their criticisms. It is your Section on General Practice, and we believe that it should function twelve months out of the year. We are at your service!

QUALIFICATIONS AND STANDARDS FOR CERTIFICATION IN THE GENERAL PRACTICE OF MEDICINE

The committee on Certification of the General Practice of Medicine in Indiana met January 27, 1946, and approved certain qualifications and standards for applicants to the Founders Group. The Founders Group will consist of two hundred members.

Competent general practitioners who wish to apply for the Founders Group, and who have had not less than ten years in general practice, may obtain an application blank at the Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis. All applications filed by March 31, 1946, will be considered by the committee at its next meeting.

The purposes as set forth by the committee are:

1. To encourage the study, improve the practice, and elevate the standards of the General Practice of Medicine.
2. To aid in improving the educational opportunities of general practitioners.
3. To determine the competence of the practitioners who desire special recognition.
4. To arrange, control, and conduct examinations to test the qualifications of the general practitioners desiring certification.
5. To grant and issue certificates of qualification to candidates successful in demonstrating their proficiency.
6. To serve the public, hospitals, and medical schools. We believe that no valid argument can be made against the claim that the best, and certainly the cheapest, medical care is that given by a competent general practitioner. He has the affection and confidence of his patients. He knows their family background, personal traits, vices and virtues.
7. To attract the ablest men to the general practice of medicine. We believe that there is an unhealthy growth of specialism at the expense of the general practice, due to many men drifting into specialties.
8. To enable the general practitioner to give adequate attention to conditions of special character and enable him to recognize the clinical situation that calls for special consultation.

The Committee on Certification of the General Practice of Medicine.

ANNUAL SESSION OF AMERICAN MEDICAL ASSOCIATION

Indiana physicians have been invited to join with fellow practitioners from other mid-western states in making up a special Pullman train to San Francisco, California, for the annual meeting of the American Medical Association, July 1 to 5.

The Oklahoma State Medical Association is organizing the tour. The all-Pullman train will depart from Kansas City, Missouri. State associations may have their own Pullman car if thirty to thirty-five persons sign up for the trip. If there is an "Indiana car," it will leave Indianapolis and become a part of the special train at Kansas City.

Going west, the train will stop for a half day at either Reno, Nevada, or Salt Lake City, Utah, for sightseeing. After the four days' session in San Francisco the train will head north, going through Seattle, Washington, and over the Canadian Pacific to Lake Louise, then to Yellowstone National Park, and back to Kansas City. The "Indiana car" would then proceed to Indianapolis. The tour will take about two weeks.

All expenses, except meals, including hotel accommodations in San Francisco, will be included in the tour rate, which will be about $185.00.

GAMMA GLOBULIN—AVAILABILITY AND INDICATIONS

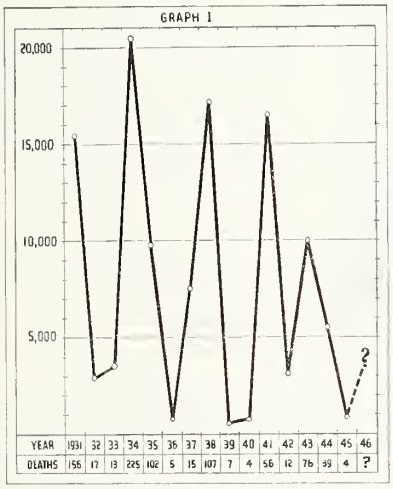
GEORGE M. BROTHER, M.D.

Director, Bureau of Preventable Diseases, Indiana State Board of Health

INDIANAPOLIS

The advantages and superior effectiveness of gamma globulin over placental extract, convalescent serum, and normal serum in the prophylaxis of measles have been reported by numerous workers.[1, 2] On the basis of all reports reviewed to date, *gamma globulin is the material of choice in the prophylaxis of measles.*

Previous announcements have been made regarding release of this valuable blood product for the civilian population. It would appear timely to call further attention to its availability in the face of a probable marked increase in the incidence of measles during the present season and year. Graph I shows the three-year cyclic trend of measles and indicates a high probable incidence for the current year. Early reports tend to bear out this prediction.



GRAPH 1. Incidence of measles in Indiana, 1931 through 1945 (showing three-year cyclic trend.)

In accordance with the plan announced by the American Red Cross, gamma globulin is available to the official state health agencies for free distribution to physicians, hospitals, and clinics, with the provision that it will be administered in accordance with the established standards and without any charge to the patient for the globulin. This action is in keeping with the policy of the American Red Cross to return to the American people, so far as practicable, any useful blood derivatives accumulated in excess of military needs, as a result of its blood-donor program.

Numerous articles have been published in recent literature concerning gamma globulin and its effectiveness in the prevention and modification of certain communicable diseases.[3, 4, 5] The following statement prepared by C. A. Janeway, M.D., of the Harvard Medical School, for distribution by the American Red Cross, consolidates some of the important points regarding this blood product, including the present indications for its use:

"This preparation is a concentrate containing the antibody globulins derived from pooled normal human plasma collected by the American Red Cross. Preparations of gamma globulin antibodies are standardized so that the concentration of antibody is twenty-five times that of the plasma pool from which it came. Since each pool is obtained from several thousand donors, variations in titer in measles antibody should be slight. Each preparation is tested for potency in the laboratory by tests for antibodies which can be readily measured. Whenever possible its potency is checked in a series of patients exposed to measles, before release for general use. This material should be kept in the icebox like other biologicals. The dating period at present is set at one year. It is probable that it will retain its potency for longer periods of time.

"*Indications*—At present this material is released *only* for the prevention and modification of measles by passive immunization. Other possible uses are being studied, but insufficient data are available to evaluate its efficacy in these circumstances. Its use in the treatment of measles or the treatment or prophylaxis of other childhood diseases is not recommended at present.

"*Administration and dosage*—This material may be administered, when indicated, to patients who have had a definite exposure to measles in the infectious stage. Its use to prevent or modify the disease is at the discretion of the physician. For prevention, a dose of .08 to 0.1 cc. per pound body weight should be given as soon after exposure as possible, but will be fairly effective in the first

[1] Greenberg, M.; Frant, S.; and Rutstein, D. D.: "Gamma Globulin" and "Placental Globulin"—A Comparison of Their Effectiveness in the Prophylaxis of Measles, *J.A.M.A.*, **126**:944-947, 1944.

[2] Janeway, C. A.: Blood and Blood Derivates, *Am. J. Pub. Health*, **36**:1-14. 1946.

[3] Stokes, J., Jr.; Maris, E. P.; and Gellis, S. S.: Chemical, Clinical, and Immunological Studies on the Products of Human Plasma Fractionation. XI. The Use of Concentrated Normal Human Serum Gamma Globulin (Human Immune Serum Globulin) in the Prophylaxis and Treatment of Measles, *J. Clin. Investigation*, **23**:531, (July) 1944.

[4] Ordman, C. W.; Jennings, C. G.; and Janeway, C. A.: Chemical, Clinical, and Immunological Studies on the Products of Human Plasma Fractionation. XII. The Use of Concentrated Normal Human Serum Gamma Globulin (Human Immune Serum Globulin) in the Prevention and Attenuation of Measles, *J. Clin. Investigation*, **23**:541, (July) 1944.

[5] Janeway, C. A.: Clinical Use of Products of Human Plasma Fractionation. I. Albumin in Shock and Hypoproteinemia. II. Gamma Globulin in Measles. *J.A.M.A.*, **126**:674-680, 1944.

seven days. For modification, a dose of .02 to .025 cc. per pound body weight should be given on or about the fifth day after first definite exposure. The globulin is injected intramuscularly, preferably in the buttocks. For this a 20- or 21-gauge needle is most satisfactory. Pull back on plunger of syringe before injection to be sure needle is not in vein, *since globulin as now prepared must not be used intravenously.*

"*Caution*—The globulin is a concentrated protein solution, hence viscous and sticky. Do not fill syringe until prepared to make the injection; otherwise syringe may become frozen.

. . . . . .

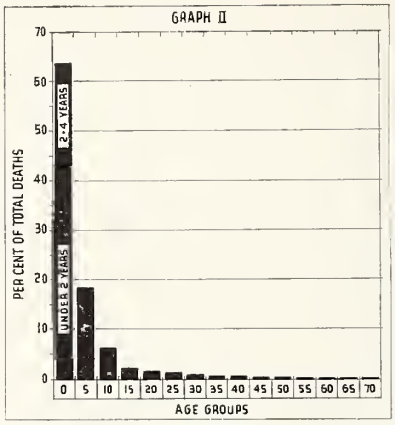
"*Safety*—A great many intramuscular injections have been given without any serious reaction and with very little local pain in the dosage recommended. Rarely, fever, irritability, or tenderness of the site may follow injection in the first twenty-four hours.

"*Duration of effect*—A single dose will probably protect a child for about three weeks. At the end of that time, if the child is re-exposed and protection is desired, the dose should be repeated.

"*Results of injection*—With any biological system in which the virulance of the virus and the resistance of the host may vary considerably, some variation in results is to be expected. With the small doses used for modification, a few patients will develop typical measles; with the large dose, used for prevention, a certain number will fail to develop any evidence of measles.

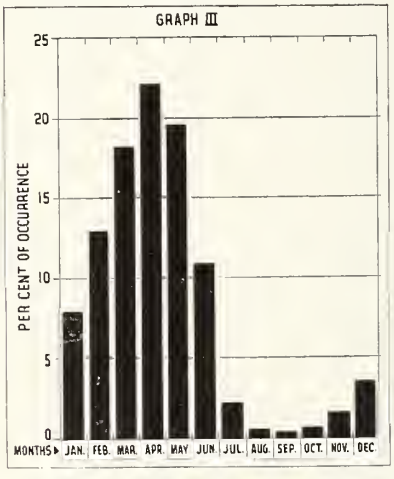
"Mild measles which results from a satisfactory modification may vary from a disease only slightly milder than the average case to one that exhibits only one or two of the stigmata of measles. Malaise and fever are usually markedly reduced; the catarrhal symptoms are slight; and rash may be evanescent and sparse."

The decision as to whether an attempt should be made to prevent or modify the disease must be individualized in consideration of the particular case. However, the preponderance of measles fatalities in the early age groups and the debilitated serves as a specific guide for the decision in those instances. It can be noted in Graph II that 42 per cent of all measles deaths in Indiana between 1931 and 1945 were in infants under two years of age, and that 64 per cent of all measles deaths were in pre-school children below five years of age.



GRAPH II. Deaths from measles during fifteen-year period, 1931 through 1945, distributed by age groups.

Graph III shows the seasonal trend of measles incidence in Indiana over a twenty-year period and indicates that a peak incidence may be expected during the early spring months.



GRAPH III. Distribution of 178,070 cases of measles, 1921 through 1940, by percentage of occurrence in each month of the year.

There is no doubt that the prompt use of gamma globulin will serve as a lifesaver, as well as to prevent many of the serious complications often resulting from measles. It is therefore the desire of the state health department to expedite the flow of this material from the generous and well-planned facilities of the American Red Cross through the physicians and hospitals to the susceptible individuals exposed to measles. Requests should be made in units of 5 cc. and on the basis of the foregoing recommended dosages. All requests from licensed physicians and hospitals addressed to the Indiana State Board of Health will receive prompt attention.

HEARINGS ON WAGNER-MURRAY-DINGELL BILL

Word has been received from the Washington office of the Council on Medical Service and Public Relations that the Senate Committee on Education and Labor will begin hearings March 18 on the Wagner-Murray-Dingell Bill now pending in Congress. The hearings are expected to run for about a month.

PENICILLIN AND VENEREAL DISEASE

MINOR MILLER, M.D.

EVANSVILLE

Since the advent of penicillin and its use in the treatment of gonorrhea and syphilis, we are facing a grave danger. Like the airplane, it gives some wonderful results when used with skill. Just as any old jallopy would not serve as a combat plane, neither will every patient respond with unvarying success to penicillin therapy. Also, as the plane, it requires trained personnel in its preparation and use.

We are having entirely too many "experts" breaking into the lay publications with statements to the effect that "we can now cure gonorrhea in one day, and syphilis in ten days." Possibly we can obtain such highly-desired results in selected cases, but at the present time this can not be achieved with any and all cases of gonorrhea and syphilis, nor by administering penicillin in any old way on any old schedule. In the past few months patients have appeared at our office, reporting that they have received 10,000 units of penicillin in a single dose daily for seven days, while others have had as little as 400,000 units, as treatment for latent syphilis. Such regimes profit nobody. The patient still has the disease, is sore at the physician, and distrustful of the drug.

An airplane must be fabricated by skilled manufacturers; so must penicillin. An airplane must be chosen for the job it is to do; so must the patient in order to be cured. An airplane requires servicing and checking to insure that it has sufficient supplies for its needs; again, likewise the patient. A plane must be handled skillfully. Even though a crack pilot might take the airplane off an Indianapolis runway and point it in the direction of Chicago, and then bail out, the resultant finish would be in the lap of the gods of chance. On the other hand, if he remains at the controls, makes his checks and applies his skill, his chance of a successful landing in Chicago is good if all details are correctly observed; otherwise, the law of gravity (the unfailing expert) would take over and disaster would ensue. Similarly, if the physician administers penicillin without checking as to the effects and results (all too often the experts) the spirochete and the gonococcus take over with undesired consequences for the patient.

One final word regarding such experts, who are frequently just some individual fifty or more miles from home: perhaps what this country needs more than a nickel cigar is an expert to devise some way to keep the "experts" at home.

DEATHS OF INDIANA PHYSICIANS IN 1945

(Compiled by James B. Maple, M.D., chairman of Committee on Necrology and History.)

(M) Member I.S.M.A.; (H) Honorary Member; (R) Retired

Name	Age	Date of Death	Address	Cause of Death on Death Certificate
Stottlemyer, Silas J. (M)	65	Jan. 3	Anderson	Cerebral hemorrhage. Essential hypertension.
Lill, Joseph C. (M)	51	Jan. 4	Fort Wayne	Pancreatic carcinoma.
Paynter, Claude B. (M)	68	Jan. 8	Salem	Coronary occlusion. Myocardial degeneration.
Nye, John H. (H)	77	Jan. 9	Cromwell	Cerebral hemorrhage.
Dobbins, Allen O. (M)	76	Jan. 12	Valparaiso	Diabetes mellitus.
McAlexander, Robt. O. (H)	77	Jan. 12	Indianapolis	Carcinoma of the stomach.
Carl, Omer U. (M)	72	Jan. 14	Peru	Perforation of gastric ulcer.
Somers, Lawrence E. (M)	54	Jan. 22	Fort Wayne	Coronary heart disease. Coronary thrombosis.
Tinsley, Edward C.	77	Jan. 26	Indianapolis	Cerebral hemorrhage. Arteriosclerosis.
Willan, Ira C.	85	Jan. 29	Morgantown	Uremia. Chronic nephritis. Prostatic hypertrophy.
Massey, Frank	86	Feb. 1	Indianapolis	Arteriosclerosis. Senility.
Defrees, Henry J. (R) (H)	83	Feb. 6	Nappanee	Ventricular fibrillation. Coronary heart disease.
Wolfe, Morton F.	41	Feb. 6	New Albany	Coronary occlusion. Hypertension.
Murphy, Samuel C. (M)	59	Feb. 10	Warsaw	Lymphosarcoma.
Burleson, Charles E. (M)	73	Feb. 10	Laporte	Coronary occlusion.
Bowers, Harvey C.	69	Feb. 11	Akron	Auto wreck. Fractured skull. Shock. Intracranial hemorrhage.
Allen, Horace R. F. (M)	76	Feb. 12	Indianapolis	Coronary occlusion. Arteriosclerosis.
Horne, Brose S.	71	Feb. 12	Gas City	Hypertension. Arterial psychosis with cerebral arteriosclerosis.
Eckhart, Godlove G. (M)	62	Feb. 26	Northwood	Chronic glomerular nephritis. Diabetes mellitus.
Asbury, Claude W.	68	Mar. 1	Hymera	Cerebral hemorrhage.
Herschleder, Maxwell (M)	60	Mar. 9	Gary	Auto-train wreck.
Gaddie, Edmund R.	68	Mar. 11	New Albany	Cerebral hemorrhage.
Cotter, Thomas F. (M)	68	Mar. 12	East Chicago	Pneumonia.
Schumaker, Eugene (M)	38	Mar. 12	Rensselaer	Coronary occlusion. C.V.R. Syndrome.
Bice, Lon C. (M)	74	Mar. 15	Edinburg	Coronary occlusion.

Name	Age	Date of Death	Address	Cause of Death on Death Certificate
Riggins, Ivan W.	71	Mar. 15	Indianapolis	Acute coronary occlusion.
Burckhardt, Louis (M)	80	Mar. 19	Indianapolis	Coronary occlusion. Fracture right femur.
Egbert, Robert H. (M)	60	Mar. 22	Martinsville	Adenocarcinoma of the pancreas. Generalized metastasis.
Smith, Thomas M.	62	Mar. 29	Jeffersonville	Cerebral hemorrhage.
Turner, Isaac N.	55	Mar. 31	Indianapolis	Coronary thrombosis. Acute nephritis.
Freshley, F. J.	60	Apr. 8	Evansville	Pulmonary T. B. Coronary thrombosis, Cardiac failure.
Garrettson, John A. (M)	66	Apr. 20	Indianapolis	Cardiovascular renal disease.
Ayling, Edmond K. (M)	74	Apr. 25	South Bend	Respiratory failure. Bronchial pneumonia.
Clark, Charles D., Capt. (M)	35	Apr. 28	South Bend	Killed by Jap suicide plane off Okinawa.
Fuller, Rudolphus W. (M)	58	Apr. 29	Anderson	Died in Michigan. Cause of death not available.
Miller, Robert B., Capt. (M)	35	Apr. 30	Argos	Died of injuries received in European theatre.
May, Frank A. (M)	62	May 2	Palmyra	Mesenteric thrombosis. Portal cirrhosis.
Fattic, John B. (M)	82	May 10	Anderson	Cerebral hemorrhage. Arteriosclerosis.
Beavers, Seth D. (M)	84	May 11	Decatur	Congestive heart failure. Myocarditis. Chronic senility.
Morris, Oliver M. (R)	81	May 14	Sheridan	Cancer of the stomach.
Eckhart, William V., Lt. (M)	29	May 17	Marion	Auto wreck. Skull fracture.
Ferguson, Charles E. (H)	88	May 18	Indianapolis	Cerebral hemorrhage. Hypertension.
McDowell, Marvin A. (M)	66	May 21	Logansport	Cerebral thrombosis. Endocarditis. Articular rheumatism. Arteriosclerosis.
Jay, Milton T.	77	May 25	Indianapolis	Cardiovascular disease. Cerebral arteriosclerosis.
Jordan, Ira H.	67	May 30	Indianapolis	Bronchopneumonia.
Tucker, Cassell C. (M)	54	June 6	Greencastle	Coronary occlusion. Coronary arteriosclerosis.
Myers, Joseph P. (R)	70	June 10	Edinburg	Coronary occlusion.
Aspy, John A. M. (M)	53	June 12	Indianapolis	Thyrotoxicosis.
Page, William B.	74	June 14	Goshen	Coronary occlusion.
Thomson, Gilbert J.	70	June 16	Terre Haute	Myocarditis.
Bartley, Donald A. (M)	58	June 16	Indianapolis	Acute cardiac failure. Coronary thrombosis. Coronary heart disease.
Perry, Ira E. (M)	72	June 18	No. Manchester	Coronary occlusion.
Brown, Charles A. (R)	83	June 18	Plymouth	Coronary occlusion. Coronary arteriosclerosis. Cardiac decompensation.
Wheeler, Homer H. (M)	73	July 3	Indianapolis	Cardiovascular collapse.
Moroney, James H. (M)	89	July 8	Winchester	Chronic degenerative myocarditis with dilatation of left ventricle.
Dunkel, John L.	80	July 10	Fremont	Heart disease.
Steible, Henry	69	July 14	Hammond	Acute cardiac decompensation. Coronary thrombosis.
Thompson, Walter N. (H)	80	July 17	Sullivan	Gastric carcinoma.
Garner, Howard A. (M)	56	July 18	Hanna	Cerebral hemorrhage.
Amos, Edward M. (M)	79	July 19	Indianapolis	Coronary occlusion.
Hufnagel, Charles J. (M)	55	July 22	Richmond	Coronary occlusion.
Hanna, Julian E.	74	July 29	Noblesville	Carcinoma of the pancreas.
Miller, Arthur G. (M)	52	Aug. 2	Hobart	Coronary thrombosis.
Stewart, Clarke E.	69	Aug. 8	Vincennes	Cardiovascular disease. Head injury, auto accident.
Seaton, Guy W. (M)	61	Aug. 12	Indianapolis	Coronary occlusion. Arteriosclerosis.
Dinnen, James M.	86	Aug. 14	Fort Wayne	Apoplexy. Generalized arteriosclerosis.
Tinsley, Frank C.	81	Aug. 23	Indianapolis	Arteriosclerosis. Septic cystitis.
Shoek, Daniel W.	74	Aug. 28	Greenwood	Cardiac failure. Coronary occlusion.
Baxter, James W., Sr. (M)	72	Aug. 28	New Albany	Cerebral hemorrhage. Arteriosclerosis.
Wilson, William (M)	85	Aug. 28	Scipio	Carcinoma of the prostate.
Van Mater, George G.	82	Aug. 29	Peru	Carcinoma of the prostate.
Cameron, Victor V. (R)	68	Sept. 3	Marion	Cerebral hemorrhage. Hypertension. Hemiplegia.
Wainscott, Oscar C. (R)	75	Sept. 3	Peru	Cancer of the prostate.
Richards, Renos H. (M)	75	Sept. 9	Patricksburg	Coronary occlusion.
Whitlatch, Binc (M)	70	Sept. 9	Milan	Myocardial failure. Coronary thrombosis.
Gannon, Richard B. (M)	41	Sept. 20	Gary	Acute myclogenous leukemia.
Denny, Charles W. (M)	77	Sept. 26	North Madison	Coronary thrombosis. Diabetes mellitus.
Courtney, Thomas E. (M)	77	Sept. 27	Indianapolis	Coronary thrombosis. Bronchopneumonia.
Ankenbrock, William S. (M)	49	Sept. 28	Indianapolis	Cerebral hemorrhage.
Leckrone, Milton E. (M)	44	Oct. 1	Rochester	Coronary embolism.
Spencer, William A. (M)	73	Oct. 5	Wolcott	Chronic myocarditis.
Schneider, Anthony J. (M)	70	Oct. 9	Indianapolis	Auto-train accident.
Webb, John W. (M)	65	Oct. 9	Indianapolis	Coronary thrombosis.
Swantusch, Otto H. (M)	61	Oct. 13	Angola	Coronary occlusion.
Stewart, Oscar H. (R) (H)	85	Oct. 19	Orleans	General leukemia. Malignancy of prostate.
Schuman, Oliver V. (M)	81	Oct. 23	Columbia City	Diabetes mellitus.
Dale, Burnham C. (M)	74	Oct. 26	Marion	Coronary occlusion.
Brown, Clarence W. (M)	48	Nov. 1	Rolling Prairie	Acute auricular fibrillation. Coronary occlusion.
DeMotte, Jerome (M)	66	Nov. 5	Odon	Exhaustion from acute mania.
Richardson, George G. (R)	64	Nov. 8	Marion	Coronary occlusion.
Dick, Charles G.	79	Nov. 25	Elwood	Hypostatic pneumonia. Senile psychosis.
Rogers, Clarke (M)	67	Dec. 21	Indianapolis	Coronary occlusion. Arteriosclerotic cardiovascular disease.
Bigger, William M.	74	Dec. 30	Hammond	Uremia. Chronic general vascular arteriosclerosis. Coronary sclerosis. Myocardial failure.
Funk, Vance A. (M)	63	Dec. 31	Vincennes	Arteriosclerosis. Coronary occlusion.

PHYSICIANS RELEASED FROM SERVICE

Medical Corps Officers Separated from Active Duty

(This is a continuation of the lists published in the October, 1945, and January, 1946, issues of THE JOURNAL.)

ADAMS COUNTY

Eicher, Palmer O.——Decatur
Grandstaff, Floyd L.——Decatur

ALLEN COUNTY

Bolman, Ralph M.——Fort Wayne
Brown, Frederick W.——Fort Wayne
McDowell, George A.——Fort Wayne
Schellhouse, Earl M.——Fort Wayne

BARTHOLOMEW COUNTY

Zaring, Byron K.——Columbus

CARROLL COUNTY

Godersky, George——Flora
Wagoner, George——Delphi

CASS COUNTY

Hedde, Eugene Lee——Logansport
Keefe, Thomas L.——Logansport
Winters, Donald K.——Logansport

CLARK COUNTY

Isler, N. C.——Jeffersonville
Reeder, Henry H.——Jeffersonville

CLAY COUNTY

Davis, Sam J.——Brazil
Oswalt, James T.——Brazil
Wood, Opal L.——Brazil

CLINTON COUNTY

Grove, Robert H.——Rossville
Hedgecock, Robert A.——Frankfort

DAVIESS-MARTIN COUNTY

Lindsay, Hamlin B.——Washington
McNaughton, Lawrence——Washington

DEARBORN-OHIO COUNTY

Jackson, John K.——Aurora
Mueller, Paul F.——Lawrenceburg
Olcott, Charles——Aurora
Pfeifer, Jerome M.——Lawrenceburg

DECATUR COUNTY

Blemker, Russell M.——Greensburg
Callaghan, Winship C.——Greensburg

DELAWARE-BLACKFORD COUNTY

Deutsch, William——Muncie
Dodds, James U.——Hartford City
Henderson, R. A.——Muncie
Hill, Howard E.——Muncie
Hill, Robert——Muncie
Larmore, Joseph L.——Muncie
McClintock, James A.——Muncie

DUBOIS COUNTY

Held, A. H.——Huntingburg
Williams, Fielding P.——Huntingburg

ELKHART COUNTY

Bolin, Robert F.——Elkhart
Davidson, Morris——Elkhart
Neidballa, Edward G.——Bristol
Pancost, Vernon——Elkhart
Price, Douglas W.——Nappance

FAYETTE-FRANKLIN COUNTY

Dale, Maxwell H.——Connersville

FLOYD COUNTY

Edwards, William F.——New Albany
Hewlett, Thomas H.——New Albany

FOUNTAIN-WARREN COUNTY

Maris, Lee J.——Attica
Smith, Byron J.——Kingman
Stephens, Lowell R.——Covington

GIBSON COUNTY

Folck, John K.——Princeton
McCarty, Virgil——Princeton

GRANT COUNTY

Abel, Charles F.——Marion
Ayres, W. W.——Marion
Baskett, Russell J.——Jonesboro
Ganz, Max——Marion
Hummel, Russell M.——Marion

GREENE COUNTY

Graf, Jerome A.——Bloomfield
Fender, Asa H.——Worthington
Mount, M. S.——Bloomfield
Porter, Carl M.——Jasonville

HAMILTON COUNTY

Ambrose, Jesse C.——Noblesville
Hash, John S.——Noblesville
Olvey, Otis N.——Noblesville

HANCOCK COUNTY

Ferrell, Mars B.——Fortville
Gill, Dee D.——Greenfield
Kuhn, Robert W.——Wilkinson

HENDRICKS COUNTY

Parke, Delmer D.——Lizton
Stafford, William C.——Plainfield

HENRY COUNTY

Amos, Robert L.——Newcastle
Burnett, Arthur B.——Newcastle
Iterman, George E.——Newcastle
Mills, John F.——Newcastle
Robertson, William S.——Spiceland
Smith, Robert——Newcastle
Stout, Walter M.——Newcastle

HOWARD COUNTY

Hutto, William H.——Kokomo
Kimmick, John M.——Kokomo
Morrison, David A.——Kokomo
Phares, Robert W.——Greentown
Spangler, J. S.——Kokomo

JACKSON COUNTY

Day, William Durbin——Seymour
Heinrich, G. E.——Ewing
Merrell, Basil M.——Brownstown
Shields, Jack A.——Brownstown

JASPER-NEWTON COUNTY

Beaver, Ernest R.——Rensselaer
Kresler, Leon——Rensselaer
Schantz, Richard——Remington

JEFFERSON COUNTY

Beetem, Luther F.——Madison
Sharman, Edward——Madison
Shuck, Wm. A.——Madison

JAY COUNTY

Morrison, George G.——Portland

JENNINGS COUNTY

Thayer, Bennet William——North Vernon

JOHNSON COUNTY

Brown, George E.——Greenwood
Menza, Michael——Edinburg

KNOX COUNTY

Chattin, Herbert O.——Vincennes
Chattin, Vance J.——Vincennes
McDowell, Mordecai M.——Vincennes
McMahan, Virgil C.——Vincennes
Warren, John C.——Bicknell

KOSCIUSKO COUNTY

Freeman, Joseph W.——Syracuse

LAKE COUNTY

Adler, Edmund——Dyer
Arnold, Marion F.——East Chicago
Brown, David B.——Gary
Carlo, Joseph F.——Hammond
Cohen, Benjamin B.——East Chicago
Cotter, Edward R.——East Chicago
Cushman, Joseph B.——Gary
Ferrara, Joseph F., Jr.——Gary
Garfield, Martin D.——Hobart
Hickman, A. L.——Hammond
Lapid, Gilbert G.——East Chicago
LaFata, Francis P.——Gary
Rosenbloom, Philip J.——Gary
Sala, Joseph C.——Gary

LA PORTE COUNTY

Bailey, Arby Lee——Michigan City
Benz, Owen F.——Wanatah
Korn, Jerome M.——Michigan City
Sanderson, Richard J.——Westville

LAWRENCE COUNTY

Allen, L. H.——Bedford
Bridwell, Edgar G.——Bedford

MADISON COUNTY

Drake, John C.——Anderson
Hoppenrath, W. M.——Elwood
King, Joseph W.——Anderson
Long, Paul L.——Anderson
McLaughlin, Calvin P.——Pendleton
Rozelle, Clarence V.——Anderson
Sharp, William L.——Anderson
Stellner, Howard A.——Pendleton

MARION COUNTY

Aldrich, Harry——Indianapolis
Arbogast, J. L.——Indianapolis
Arbuckle, Russell L.——Indianapolis
Aronson, Sidney S.——Indianapolis
Arnold, Aaron L.——Indianapolis
Banks, Horace M.——Indianapolis
Baumgart, E. T.——Danville, Ill.
Beaver, Ernest R.——Rensselaer
Blatt, Adolph E.——Indianapolis
Boys, Floyd E.——Indianapolis
Bretz, John M.——Indianapolis
Brother, George M.——Indianapolis
Brown, Wendell E.——Indianapolis
Browning, James S.——Indianapolis

Browning, William M.—Indianapolis
Burton, Frank H.—Indianapolis
Caplin, Samuel S.—Indianapolis
Cohen, Bernard W.—Indianapolis
Davis, George D.—Indianapolis
Denney, Forrest L.—Indianapolis
Dyar, Edwin W.—Indianapolis
Egbert, Herbert L.—Indianapolis
Fouts, Paul J.—Indianapolis
Fromhold, Willis A.—Indianapolis
Fullerton, Robert L.—Indianapolis
Gardner, Frederic B.—Indianapolis
Graves, John W.—Indianapolis
Greer, Oliver W.—Indianapolis
Gossard, Meredith—Indianapolis
Hall, Frank M.—Indianapolis
Hancock, John G.—Indianapolis
Hare, Earl H.—Indianapolis
Hatfield, Nicholas W.—Indianapolis
Hawk, James H.—Indianapolis
Hawk, Edgar A.—N. Palestine
Henry, Russell S.—Indianapolis
Hetherington, John A.—Indianapolis
Hoetzer, Eldore M.—Chicago, Ill.
Howell, Robert D.—Indianapolis
Jobes, James E.—Indianapolis
Johnson, George M.—Indianapolis
Kahler, Maurice V.—Indianapolis
Kammen, Leo—Indianapolis
Kelley, Don E.—Indianapolis
Kendrick, William M.—Indianapolis
Kirch, Leo N.—Indianapolis
Klain, Benjamin V.—Indianapolis
Leffel, James M.—Indianapolis
Little, John W., Jr.—Indianapolis
Loehr, William M.—Indianapolis
Loudermilk, Jack L.—Indianapolis
Lybrook, William B.—Indianapolis
Maly, Charles H.—Indianapolis
Marks, Howard H.—Indianapolis
Masters, John M.—Indianapolis
McKinley, A. David—Indianapolis
McQuiston, Ralph J.—Indianapolis
Moore, Harold T.—Indianapolis
Need, Louis T.—Indianapolis
Norman, William H.—Indianapolis
Pilcher, Jack E.—Indianapolis
Reed, Roger R.—Indianapolis
Reul, Thomas W.—Indianapolis
Ross, Alexander T.—Indianapolis
Scott, Ivan W.—Indianapolis
Sheehan, Francis G.—Indianapolis
Smith, William B.—Indianapolis
Spalding, Joseph J.—Indianapolis
Spivey, Russell J.—Indianapolis
Stroup, Tyler—Indianapolis
Stadler, Harold E.—Indianapolis
Tharpe, Ray G.—Indianapolis
Thatcher, Hugh K.—Indianapolis
Thomas, Morris E.—Indianapolis
Tinsley, Frank—Indianapolis
Tyner, Harlan H.—Indianapolis
Warriner, James B.—Indianapolis
Weigand, Clayton G.—Indianapolis
West, Joseph L.—Indianapolis
Worley, Joseph P.—Indianapolis

MARSHALL COUNTY

Buchanan, W. D.—Bremen
Cripe, Earl P.—Bremen
Lund, Leonard C.—Argos
Perry, Frederick G.—Plymouth
Pomeroy, R. K.—Plymouth
Thompson, John N.—Bremen

MONROE COUNTY

Holland, Charles E.—Bloomington

MONTGOMERY COUNTY

Daugherty, Fred N.—Crawfordsville
Gross, Maurice E.—Ladoga
Humphrey, John W.—Crawfordsville
Millis, Robert J.—Crawfordsville
Mount, William M.—Crawfordsville

MORGAN COUNTY

Miller, R. D.—Martinsville
Stangle, William J.—Mooresville

NOBLE COUNTY

Fair, John R.—Wolf Lake

OWEN COUNTY

Brown, Marcel S.—Spencer

PIKE COUNTY

Dickason, G. A.—Petersburg

PORTER COUNTY

Corboy, Philip M.—Valparaiso
Dittmer, Jack E.—Valparaiso
DeGrazia, Eugene—Valparaiso
Loring, Mark L.—Valparaiso
Nash, Charles B.—Valparaiso

POSEY COUNTY

Jenkinson, William E.—Mt. Vernon

PUTNAM COUNTY

Rhea, Gilbert D.—Greencastle
Tipton, William R.—Greencastle

RANDOLPH COUNTY

Chambers, Leroy B.—Union City
Unger, Louis—Farmland
Wills, Benjamin—Union City

RIPLEY COUNTY

Warn, William J.—Milan
Whitlatch, Arthur—Milan

ST. JOSEPH COUNTY

Arisman, R. K.—South Bend
Buchanan, W. D.—South Bend
Buechner, F. W.—South Bend
Firestein, Ray—South Bend
Green, G. F.—South Bend
Hewitt, Marshall—South Bend
Hillman, M.—South Bend
Lane, William—South Bend
McCraley, W. J.—South Bend
Plain, George—South Bend
Pyle, Harold D.—South Bend
Sandock, L. F.—South Bend
Selby, K. E.—South Bend
Sirlin, E. M.—Mishawaka
Spalding, W. L.—Mishawaka
Weiss, Eugene—South Bend

SHELBY COUNTY

Gehres, Robert W.—Shelbyville
Hord, Luther J.—Shelbyville
Miller, Richard C.—Shelbyville
Nigh, Rufus M.—Fairland
Richard, Norman—Shelbyville

SPENCER COUNTY

Crain, J. W.—St. Meinrad
Glackman, John C., Jr.—Rockport

STEUBEN COUNTY

Hippensteele, Ralph O.—Fremont
Kissinger, Knight L.—Angola

SULLIVAN COUNTY

Donnelly, Robert—Sullivan

TIPPECANOE COUNTY

Cox, Wayne T.—Lafayette
Herrold, George W.—Lafayette

TIPTON COUNTY

Burkhardt, Boyd—Tipton
Connoy, Leo F.—Tipton

VANDERBURGH COUNTY

Bigsby, Frank L.—Evansville
Cole, Wm. L.—Evansville
Denzer, Edward K.—Evansville
Daves, W. Lawrence—Evansville
Helper, Morton—Evansville
Leslie, E. T.—Evansville
Logan, Jesse R.—Evansville
McDonald, Joseph D.—Evansville
MacKenzie, Pierce—Evansville
Raphael, Isadore J.—Evansville
Scales, Alfred B.—Evansville
Springstun, Walter R.—Evansville
Smithson, Robert A.—Evansville
Watson, Herman L.—Evansville
Willis, Charles F.—Evansville
Wood, William H.—Evansville
Worrall, Cyrus L.—Evansville
Yunker, Philip E.—Evansville

VIGO COUNTY

Dyer, George W.—Terre Haute
Haslem, Ezra R.—Terre Haute
LaBier, Clarence R.—Terre Haute
Mattox, Don M.—Terre Haute
McEwen, James W.—Terre Haute
McLaughlin, Gordon, Jr—Terre Haute
Van Arsdall, C. R.—Terre Haute
Voges, Edward C.—Terre Haute
Weber, Joseph G. S.—Terre Haute

WABASH COUNTY

Balsbaugh, George—N. Manchester
Cook, Charles E.—N. Manchester

WASHINGTON COUNTY

Episcopo, A. R.—Salem
Gilliatt, J. P.—Salem

WAYNE-UNION COUNTY

Hill, Paul G.—Cambridge City
Hunt, Gayle J.—Richmond
Lee, Glen W.—Richmond
Jenkinson, William—Richmond
Pentecost, Paul S.—Richmond
Poston, Clement L.—Richmond
Snyder, Morris C.—Richmond
Sweet, Howard E.—Richmond

WELLS COUNTY

Gitlin, William A.—Bluffton

WHITE COUNTY

Derhammer, George L.—Brookston
Morrical, Russell J.—Wolcott

WHITLEY COUNTY

Pence, Benjamin F.—Columbia City

Military News

CAPTAIN BASIL B. DULIN RELATES EXPERIENCE AS A PRISONER OF WAR

Captain Basil B. Dulin, of Indianapolis, who became a Japanese prisoner of war while serving with the Medical Corps of the United States Army during the fall of Bataan, kindly consented to give us a short resumé of at least one of his experiences as a prisoner of war.

"When asked to tell about some of my experiences as a Japanese prisoner of war, I always hesitate and fidget around. Most of the days I spent basking in the warmth of Nipponese hospitality as a compulsory national guest were just like the preceding ones. They were characterized by an empty feeling in the midriff and by monotony. I have tried to recall a few experiences that might be considered unusual, and here is one of them:

"Two days before the surrender of Bataan my infantry regiment was having some trouble re-establishing the line. We were falling back on all sides; communications were gone; and we had no contact with any of our own forces. We finally had to withdraw from our position, and do it in a hurry in order to keep from being surrounded and cut off. The battalion surgeon and myself were told to go ahead for a distance and wait until the others caught up. We did this and waited for several hours. The rest of the outfit never showed up, and it was decided to make for the coast.

"While driving along I noticed a few pieces of timber across the road, and got out to remove them. In so doing I noticed a soldier seated on the ground asleep. I thought it was one of our own Filipino Scouts, and went over to awaken him and give him a good 'bawling out' for being asleep on the job. Just as I got to the soldier he raised his head, and I saw the little peaked cap with the gold star. It was Joe Nip with a light, air-cooled machine gun. Our faces were about three inches apart, and we had a good look at each other. The pupils of his eyes got as big as a dime. I don't know how large mine got. We were both so overcome by surprise that neither of us made a move for a few seconds. I made the first change in the situation by getting out of there as fast as possible. Joe Nip got in two good bursts at a distance of about thirty yards, and missed me both times. One bullet went through my belt, trousers, shirt tail, and shorts, but never disturbed a single epithelial cell. That is the closest I ever came to a purple heart.

"I escaped with four of my Filipino soldiers and hid in the jungle until morning. We had no compass or map. We got our direction from the sun the next morning, and set out. There was small-arms fire everywhere. We shunned the trails and scrambled through the jungle. The next afternoon contact was made with some remnants of our own forces. It was then that the reaction of fright set in. I was not worth a cuss for three days."

The above account leaves us speechless, except to say, "Captain Dulin, we are so glad to have you back with us."

Dr. Dulin has accepted a Fellowship in Medicine at the Indianapolis City Hospital, having resumed where he left off to do his part for his country.

Honor was accorded Captain Joseph R. Caton, of South Bend, in the form of a Meritorious Service Citation for work in the field of rheumatology at the William Beaumont General Hospital, at El Paso, Texas. Doctor Caton served in the hospital as consultant on arthritis prior to returning to South Bend, where he has resumed his medical practice.

A major in the First Infantry Division of the Army prior to his recent discharge, Dr. William L. Sharp, of Anderson, has returned home and will resume his practice. Doctor Sharp served for three and one-half years, including fourteen months in the European Theatre. He served with the First Infantry Division in the Battles of the Ardennes, Cologne, Remagen bridgehead, Ruhr pocket, and Southern Germany. While overseas Doctor Sharp attended a four-week course in neurology at the La Hospital Slate's Pietree, Charot's Clinic, Paris.

While on terminal leave, Dr. Fred M. Applegate, of Corydon, has been notified of his promotion from the rank of major to lieutenant colonel. Colonel Applegate returned last fall from service in the European theatre, and was selected to serve as executive officer of the Medical Corps contingent on the ship from Europe to the United States.

The Bronze Star Medal has been awarded to Commander Russell S. Henry, of Indianapolis, for meritorious service as an officer in charge of the Navy's first overseas photofluorographic unit. He also supervised the installation and operation of the chest x-ray unit at Pearl Harbor, and he designed forward area and mobile units, and installed chest x-ray equipment at the Pearl Harbor separation center within forty-eight hours after the Japanese surrender. Doctor Henry entered the service in September, 1942; is now on terminal leave; and is returning to practice in Indianapolis.

Captain George D. Beamer, formerly of Delphi, has returned recently from overseas service, and is located temporarily in Terre Haute.

Captain Owen F. Benz, formerly of Whiting, plans to practice medicine in Wanatah, following his recent discharge from military service.

Lieutenant M. Richard Harding, of Indianapolis, who entered the Medical Corps on June 8, 1945, is now stationed at Regional Hospital No. 2, at Fort Bragg, North Carolina.

After four years' service, Dr. William Deutsch, of Muncie, is now on inactive status and has returned to Muncie to practice. Doctor Deutsch, who was a major, spent two years overseas, where he was stationed in North Africa and Corsica.

Captain Arsenius R. Episcopo, formerly of Mitchell, is establishing an office in Salem, following his recent release from service. Doctor Episcopo saw four years of service in the Army, and for two years was industrial surgeon at the Army Ordnance Depot, at Tacoma, Washington.

Commander John W. Ferree, former Indianapolis physician and head of the Indiana State Board of Health, has been appointed Director of Education for the American Social Hygiene Association, in New York, and will assume his duties there following his release to inactive duty by the Navy.

Announcement has been made by Dr. W. W. Ayres, formerly of Hartford City, that he will open an office in Marion, where he will specialize in general surgery. Doctor Ayres recently returned home after three and one-half years of naval service, which included duty in the Pacific Theatre. Doctor Ayres served with the rank of Commander.

Major Ralph E. Barnett, of Peru, is now on terminal leave, and will resume his practice in Peru. Dr. Barnett entered the service July 1, 1942, and served overseas for two and one-half years as a flight surgeon with the Twelfth Air Force, having been stationed in North Africa and Italy. He wears the European, African, and Middle East ribbons, with four campaign stars.

Lieutenant Colonel Kermit F. Perrin, of Fort Wayne, plans to resume the practice of medicine there, upon completion of some postgraduate courses at the University of Wisconsin Medical School. He has completed his terminal leave and has returned to civilian status. Colonel Perrin was regimental surgeon of Headquarters Fourth Corps. He served overseas for twenty-one months in Northern Africa and Italy, and was with the first troops entering Rome after it was liberated.

Major Frank L. Bigsby, of Evansville, was recently discharged from the Army Medical Corps, at Camp Atterbury. He plans to return to practice at his former location, in Evansville.

Major Joseph P. Worley, of Indianapolis, has returned after two years' service in the Army Medical Corps, in Burma and China, and will resume his practice in Indianapolis. He entered the Medical Corps thirty months ago.

A major at the time of his discharge, Dr. Dan E. Talbott, of Indianapolis, was with the first forces to enter Japan. He was with the Army Air Forces, but has now returned to practice.

After serving in the armed forces for four years, Major Basil M. Merrell, of Brownstown, has received his discharge. He recently visited friends in Indianapolis and Brownstown.

Commander William J. Stangle, of Mooresville, is now on terminal leave, after forty-four months' service with the United States Naval Reserve. He spent nineteen months in the Southwest Pacific. He has a residency in X-ray at the Methodist hospital in Indianapolis.

Captain George W. Wagoner, formerly of Burrows, plans to begin practicing in Delphi following his recent release from service with the Armed Forces. Doctor Wagoner entered the service in July, 1942, and following his basic training he was sent to the station hospital at the Army Air Field, in Boca Raton, Florida, where he was stationed for more than two years.

Murray E. Harden, M.D., of Covington, has been promoted from captain to major, and has been transferred to the Separation Center at Camp Atterbury. Major Harden was formerly on duty with the Operations Service, Training Division, School Branch of the Surgeon General's Office.

Another Indianapolis physician who has returned to private practice is Captain Robert L. Fullerton, after four years' service in the Army Medical Corps. Attached to the staff of the 53rd General Hospital, which remained in England throughout the European campaign, Doctor Fullerton is now on terminal leave.

Major Edmund B. Haggard, of Indianapolis, recently released from the Army Medical Corps, plans to resume his practice in Industrial Surgery. Doctor Haggard entered the service on July 1, 1942. He spent one year at Plattsburg Barracks, New York, as personal physician at the Air Force Convalescent Hospital. He reports that he was up to see Colonel Phillip Cochran's Air Commandoes, near the Burma border—visited and lived with them.

Formerly of Pendleton, Dr. C. P. McLaughlin will resume his medical practice in Anderson, following his recent release from the service, where he served with the rank of lieutenant colonel.

A former Medora physician, Captain Jack E. Shields plans to open an office in Brownstown following his recent release from the armed services. Doctor Shields entered the service in July, 1943; spent eleven months at various stations in the United States; and was then sent to the Mediterranean Theatre of Operations. In that area he served for sixteen months with a bomber group of the 12th Air Force.

Colonel E. M. Sirlin, of Mishawaka, reports that after quite a search he has found an office in which to return to civilian practice, after almost five years of military service. He was stationed in Newfoundland for two years; then in Alaska and Canada for sixteen months, with the United States Engineer Construction Forces Health Services. He supervised the health of civilian workers on airports, harbors, canal projects, and the Alaskan highway, and wound up at Brooke General Hospital, Fort Sam Houston, Texas. He is now on terminal leave.

Major Howard A. Stellner, of Indianapolis, has just returned from Tokyo, where he was with the 54th General Hospital. He was the assistant chief, and later chief, of the Neuropsychiatric Service. He operated for a year at Hollandia, New Guinea, then went to Tokyo. The 54th General Hospital was the largest hospital in the Pacific Area. Doctor Stellner's whole unit was given the Meritorious Service Award for participation in the New Guinea campaign. He entered the service on July 12, 1942, and was in Tokyo from October 13, 1945, to January 15, 1946. Doctor Stellner reports that Lieutenant Colonel E. Wayne Carson, of Indianapolis, is still in Tokyo, and that the name of the hospital has now been changed to the 27th General Hospital.

After two years service in the Pacific, as chief of Medical Service in the 161st Station Hospital, Lieutenant Colonel James S. Browning, of Indianapolis, is home on terminal leave. The 161st was the second hospital to enter Japan, arriving there on September eighth, and the first to set up for operation on the mainland. It arrived in Japan shortly after the 42nd General Hospital, which was on a hospital ship and set up right on the docks in the Tokyo-Yokohama area for the purpose of processing American Prisoners of War. The 161st moved eleven miles inland, to the Totsuka Naval Hospital, and had the satisfying experience of evicting Japs from their own hospital. Doctor Browning was assigned first to the 32nd General Hospital, but was transferred later to the 161st Station Hospital, at Camp Swift, Texas, which went overseas in November, 1943. He has returned to practice at his former location, in Indianapolis.

Colonel Oliver W. Greer, of Indianapolis, has resumed his position as director of the Division of Services for Crippled Children, Indiana Department of Public Welfare. A surgeon of the Sixth Corps, Seventh Army, Doctor Greer was in service for five years, and his duty took him to six European countries.

Lieutenant Commander Wendell E. Brown has resumed the practice of pediatrics at his former location in Indianapolis. He returned to the United States in December, and was given a discharge shortly thereafter. Commander Brown entered the service in August, 1942, and first served on a transport in 1942 and 1943, taking part in the invasion of North Africa and Sicily. He was then stationed at the Naval Hospital at Oakland, California, for a year, doing pediatrics at the Family Clinic; then after a course in tropical diseases he was sent to the Philippines, where he had charge of an Epidemiology Unit, and where he remained until his return to the United States for discharge.

Captain J. Neill Garber, of Indianapolis, who is now connected with the 361st Station Hospital, in Japan, writes that some changes in the system of discharging men in service there are to be made. He said, "Those with highest scores and longest overseas time will go home despite the fact that they may not have quite the requisites for actual discharge . . . the first real common-sense, practical attitude I have seen since leaving Europe.

"We are not particularly busy at present. Automobile accidents here are notably fewer and less serious than was the case in the E.T.O. following V-E Day. The ratio of surgical cases to medical runs around 1 to 3—much of the latter is recurrent malaria, originally contracted in the tropics, and venereal disease. I am rather intimately associated with our own statistics now as I have been chief of the Surgical Service since December twenty-second.

"There hasn't been much of an opportunity to see the country beyond Hiroshima, except for one of Japan's famed shrine islands nearby, called Itsubu Shima. A few days ago several of us went up there in a confiscated Jap power cruiser—it's a small island with this large shrine on the hill. There one sees a large wood building with a pagoda nearby. The surrounding part is beautiful and the walls are lined with stone, lantern-like religious symbols all the way. Souvenir shops are abundant.

"Japan's roads are not extensive—all travel out of here is either by train or air, and Hiroshima is one of the chief intersections between us and the North. Strangely enough, the Atomic Bomb did not affect the railroads in the town—it is said that relief supplies were in there by rail soon after the explosion. By the way, I have a copy of an eye-witness account of that holocaust, written by a German priest at a Catholic institution there."

News Notes

The election of Dr. Cleon A. Nafe, of Indianapolis, as president of the National Conference on Medical Service for 1946, brought a distinct honor to the Indiana State Medical Association. Doctor Nafe is chairman of the Executive Committee, and immediate past president of the Indianapolis Medical Society.



Cleon A. Nafe, M.D.

The election took place on February 10, 1946, at the nineteenth annual session of the conference, at the Palmer House, in Chicago. Dr. Nafe had served as secretary for two years. The 1946 program was under the auspices of the Indiana State Medical Association, and was considered one of the best ever offered. Included on the program were nationally-known speakers from medicine, industry, labor, agriculture, and business. Approximately two hundred fifty persons attended the meeting. The conference meetings are held at the time of the Conference of State Secretaries and Editors, of the American Medical Association, and the Congress on Medical Education and Licensure.

Dr. Creighton Barker, executive secretary of the Connecticut State Medical Society, was elected secretary to succeed Dr. Nafe. Connecticut will sponsor the 1947 meeting.

Dr. Laura Hare, of Indianapolis, entered private practice recently. She is located in the office with Dr. Mary Alice Norris, at 404 Hume Mansur Building.

MEETING OF THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians will hold its annual meeting in Philadelphia, May 13-17, inclusive, at the Philadelphia Municipal Auditorium, 34th Street below Spruce.

Dr. Milton S. Ross, of Columbus, health director of the Columbus District of the Indiana State Board of Health, has been transferred to the United States Marine Hospital, at Buffalo, New York. Dr. Daniel Barrett, who was formerly director of the Bloomington District, will succeed him. Doctor Ross is a member of the United States Public Health Service, and came to Columbus in June, 1942, under a loan arrangement to the Indiana State Board of Health during the war emergency.

Dr. R. L. Sensenich, of South Bend, has been elected chairman of the Board of Trustees of the American Medical Association.

Dr. Otis R. Lynch, of Marengo, has been named Crawford County health officer, to succeed Dr. N. E. Gobbel, of English.

Succeeding the late Dr. Herman G. Morgan, Dr. Charles W. Myers, superintendent of the Indianapolis City Hospital for the past fifteen years, has been named as secretary of the City Board of Health.

Notice!

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation has announced that its annual prize contest will be conducted again this year. Further information can be secured by addressing Dr. James R. Bloss, 418 11th Street, Huntington 1, West Virginia.

Formerly county health officer, Dr. H. B. Turner, of Worthington, has been appointed county jail and infirmary physician for 1946, and has been succeeded as county health officer by Dr. George Moses, of Worthington, who was named for a four-year term.

Announcement has been made by Governor Ralph F. Gates of the appointment of Dr. E. Rogers Smith, of Indianapolis, as a member of the Indiana Council for Mental Health, a vacancy occurred by the death of Dr. Larue Carter. Doctor Smith will serve on the council until December 12, 1947. This council carries responsibility for planning the mental screening hospital to be constructed at the campus of the Indiana University Medical Center. Doctor Smith recently returned to private practice after serving as a commander in the Navy, and was in charge of Neuropsychiatric Services in Navy Hospitals in the South Pacific. Prior to entering service he had also served as a professor of Mental and Nervous Diseases at the Indiana University Medical Center.



E. Rogers Smith, M.D.

Governor Ralph F. Gates has named Dr. Walter H. Baker, of South Bend, as a trustee of the proposed Northern Indiana Crippled Children's Hospital. He will serve for four years.

Dr. Paul D. Crimm, of Evansville, has been honored by being elected president of the Alpha Kappa Kappa, at the recent international convention held in Cleveland. Alpha Kappa Kappa has chapters in forty-five medical schools in the United States and Canada. Doctor Crimm has been grand historian of the fraternity, and also editor of its magazine, *The Centaur*.

The Indianapolis (Marion) County Medical Society members held a dinner-dance at the Indianapolis Athletic Club, on January twelfth, a heretofore annual affair which was resumed following a five-year lapse. A talk by Dr. Cleon A. Nafe, retiring president, preceded the dance. Members of the social committee arranging the event included Dr. William V. Woods, Dr. Norman S. Loomis, Dr. Roy V. Myers, Dr. Russell A. Sage, Dr. Clifford H. Jinks, Dr. William E. Gabe, Dr. H. L. Collins, Dr. Martha Souter, and Dr. Glenn C. Lord.

A seven-man medical board to function in connection with the South Bend-St. Joseph County Veterans Service Commission was appointed recently by the Board of County Commissioners. Dr. A. S. Giordano, of South Bend, is chairman of the board; the other members are Dr. R. L. Sensenich, Dr. C. J. Langenbahn, Dr. Alfred Ellison, Dr. Lester G. Ericksen, and Dr. David H. Condit, all of South Bend, and Dr. Merle E. Whitlock, of Mishawaka. The primary function of the board will be to act in an advisory capacity in all matters pertaining to veterans' health.

Dr. John L. Arbogast, of Indianapolis, recently discharged from the Army Medical Corps after forty-two months' service in the India-Burma area, has been named director of the clinical laboratory of the Indiana University Medical Center, to succeed Dr. Clyde G. Culbertson, who has resigned.

Doctor Culbertson, who established the clinical laboratory in 1931 and made it one of the outstanding laboratories in the United States, will become a member of the research staff of Eli Lilly and Company.

Doctor Arbogast graduated from the Indiana University School of Medicine in 1936; served a rotating internship in the Indiana University hospitals in 1936 and 1937, and then served as resident in clinical pathology under Dr. Culbertson three years. Before entering the Medical Corps he served as clinical pathologist at Lafayette for two years. While in the Medical Corps he served as pathologist at an Army Hospital and did important research work on the so-called "Japanese tick fever."

The staff of the Veterans Facility, at Marion, has been increased by twenty doctors, five of whom are specialists. The increase was authorized under the new medical program for the Veterans Administration. Addition of the new doctors will give the Marion facility a staff of thirty-two physicians.

On February first, Dr. Clyde G. Culbertson, of Indianapolis, became associated with the Biological Division of the Eli Lilly and Company Research Laboratory. He was formerly Professor of Pathology and Director of the Clinical Laboratory at the Indiana University School of Medicine, where he had been associated for the past fifteen years.

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA

The 1946 assembly of the Interstate Postgraduate Medical Association of North America will be held at the Public Auditorium in Cleveland, Ohio, October 15 to 18, 1946. An invitation has been extended to all Indiana members to attend this meeting.

UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the award is based on the merits of the work presented. Competitors shall be limited to residents in urology in recognized hospitals, and to urologists who have been in such specific practice for not more than five years.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Netherland Plaza, Cincinnati, Ohio, July 22-25, 1946.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before July 1, 1946.

1947 EXHIBITION OF AMERICAN PHYSICIANS ART ASSOCIATION

The ninth exhibition of the American Physicians Art Association to be held at Atlantic City in 1947, on the occasion of the Centennial Session of the American Medical Association, will also be the occasion of the judging of the "Courage and Devotion Beyond the Call of Duty" Art Prize Contest ($34,000 in Savings Bonds). This contest was originally scheduled for the 1946 Session, but has been postponed one year in order to give more physicians an additional year to complete their art pieces on this special prize subject. For further information regarding both the San Francisco, 1946, and the Atlantic City, 1947, Art Exhibits, write either the American Physicians Art Association Secretary-Treasurer, Dr. Francis H. Rodewill, Flood Building, San Francisco, California, or the sponsor, Mead Johnson & Co., Evansville 21, Indiana.

Dr. Augustus P. Hauss, of New Albany, has been appointed a member of the Indiana Advisory Health Council, by Governor Ralph F. Gates.

Dr. Jerome E. Holman, of Indianapolis, has been elected president of the Board of Managers of the Marion County Tuberculosis Hospital, at Sunnyside. Dr. William M. Dugan is a member of the board.

Dr. Gerald F. Kempf, of Indianapolis, has been named director of the Indianapolis Board of Health, succeeding the late Dr. Herman G. Morgan. Doctor Kempf had served as assistant city health director since January, 1945, and prior to that time was a member of the laboratory staff of Eli Lilly & Company for sixteen years.

Although he is practicing in India at the Sewa Bhawan Hospital, Dr. Herbert E. Dester, a 1926 graduate of the Indiana University School of Medicine, maintains his membership in the Indianapolis (Marion County) Medical Society. Doctor Dester is a medical-missionary in charge of medical work in the area around Jagdeesphur. He writes that in spite of the fact that none of the nurses or pharmacists have had more than an eighth-grade education, they do nursing, laboratory work, give anesthetics, and assist in major operations. Doctor Dester will return to the United States in April on a furlough.

MEDICAL OFFICERS WANTED BY UNITED STATES PUBLIC HEALTH SERVICE

Examinations for appointments of medical officers in the Regular Corps of the United States Public Health Service will begin on April 4 at various convenient localities throughout the country, Surgeon General Thomas Parran has announced. Examinations are for appointments to fill vacancies of Assistant Surgeon (First Lieutenant) and Senior Assistant Surgeon (Captain). Regular Corps appointments are permanent. They provide qualified doctors with opportunities for a career in one or more of a number of fields, including research, general hospitals, special hospitals, foreign duty, and public health programs. Entrance pay for Assistant Surgeon with dependents is $3,411 a year, and for Senior Assistant Surgeon with dependents is $3,991 a year. Promotions are at regular intervals up to and including the grade of Medical Director which corresponds to full Colonel at $7,951 a year. Retirement pay at sixty-four is $4,500 a year. Full medical care, including disability retirement at three-fourths pay is provided. All expenses of official travel are paid by the Government. Thirty days' annual leave with pay is provided.

Application forms may be obtained by writing to the Surgeon General, United States Public Health Service, Washington 25, D. C.

In a decentralization move, five branch offices of the Indiana State Board of Health are to be opened, each office having a minimum personnel consisting of a medical director, sanitary engineer, consultant nurse, supervising nurse, health education consultant, venereal disease investigator, milk sanitarian, food and drug sanitarian, and clerks. Each branch office will serve approximately eighteen counties, and will be located in Washington, Fort Wayne, Valparaiso, Columbus, and the fifth in the West-central area, the city not yet having been determined.

POSTGRADUATE COURSE BY AMERICAN COLLEGE OF CHEST PHYSICIANS

A postgraduate course in "Diseases of the Chest" will be given under the auspices of the Illinois Chapter of the American College of Chest Physicians, at the Michael Reese Hospital, Chicago, Illinois, during the week April 1 to 6, inclusive.

Doctors may elect to follow this week's formal course with practical instruction in the fields of thoracic surgery, bronchoscopy, pneumothorax, bronchography, and other methods and technics in the diagnosis and treatment of pulmonary disease.

Further information may be secured by writing to the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10 Illinois.

Dr. Walter Stoeffler, of Indianapolis, has joined the staff of the Indiana State Board of Health. As Pediatric Consultant in the Division of Maternal and Child Health, he will assist in the development of the child and infant health program in Indiana.

Dr. Stoeffler graduated from the Indiana University School of Medicine, served his internship in the Indianapolis City Hospital, and then studied for two and one-half years in the Boston City Hospital, the Boston Children's Hospital, and the Boston Infant's Hospital. Having completed his early training, he returned to Indianapolis, where he entered private practice.

With the advent of war, Dr. Stoeffler was enlisted in the Navy with the rank of lieutenant commander. He was ordered to duty at the new Naval Medical Center at Bethesda, Maryland, where he studied the problems of preventive medicine and sanitation as applied to military personnel and installations. He was later assigned to various naval centers in the United States, to assist in developing preventive medicine programs.

In the spring of 1945, Commander Stoeffler was ordered to the South Pacific. He was on Okinawa as staff officer in charge of preventive medicine until November first, when he returned to this country. In July, 1945, while still on Okinawa, he was promoted to the rank of commander.

Doctor Stoeffler will prove a valuable addition to the staff of the Indiana State Board of Health.

Deaths

Larue D. Carter, M. D., noted Indianapolis neuropsychiatrist, died on January twenty-second at his home following an illness of several weeks' duration. He was sixty-five years of age. Doctor Carter was prominent in medical circles, serving as professor of Neurology in the Department of Neuropsychiatry at the Indiana University School of Medicine, and as chief of the neuropsychiatry staff at the Indianapolis City Hospital. He was chairman of the Indiana Council for Mental health, and was chairman of Governor Gates' committee on arranging for the new mental screening hospital to be constructed on the campus of the Indiana University School of Medicine. It has been announced that in tribute to Doctor Carter, and in recognition of his outstanding work, this new hospital is to be known as the Larue Carter Memorial Hospital.



Larue D. Carter, M.D.

Doctor Carter graduated from the Medical College of Indiana, in Indianapolis, in 1904. In 1916 he entered the Medical Corps, remaining in service until 1919, when he was discharged with the rank of colonel, in World War I.

During World War II he was medical liaison officer for Indiana, for the Fifth Service Command.

Doctor Carter was a member of the Central Neuropsychiatric Association, and the Association of Military Surgeons; he was a Fellow of the American College of Physicians, and a Diplomate of the American Board of Psychiatry and Neurology. He was also a member and past president of the Indianapolis (Marion County) Medical Society, a member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

Jacob V. Baker, M. D., of Edinburg, died on January eleventh as a result of injuries sustained in an automobile accident which occurred while Doctor Baker was on his way to make a professional call. He was seventy-eight years of age. Doctor Baker was a graduate of the Hospital College of Medicine, in Louisville, in 1898, and had practiced medicine in Edinburg since 1909. He was especially interested in pediatrics. Doctor Baker was a member of the Johnson County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Joseph Reed Crowder, M. D. of Sullivan, died suddenly on January twenty-second, in New Smyrna, Florida, where he had gone for a rest. Doctor Crowder was seventy-one years of age. Upon graduation from the Rush Medical College, in Chicago, in 1897, Doctor Crowder returned to Sullivan to practice, and had practiced there for forty-nine years. Doctor Crowder was a member and former president of the Sullivan County Medical Society, a member of the Indiana State Medical Association, and a Fellow of the American Medical Association.

Vance A Funk, M.D., of Vincennes, died on December thirty-first, at the age of sixty-three. He graduated from the University of Nashville Medical Department in 1909, and located in Vincennes in 1912. He practiced surgery there until his retirement in November, 1944. Doctor Funk was a member of the American College of Surgeons. He was also a member of the Knox County Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Herman Call Runyan, M.D., of Alexandria, died on January eighth at his home after a short illness. He was sixty-eight years of age. In 1906 he graduated from the Rush Medical College, in Chicago, and practiced in Chicago until the opening of World War I, when he entered the service and received his commission at Fort Oglethorpe, Georgia. In World War II, Doctor Runyan was an instructor in the Civilian Defense Corps. For many years Doctor Runyan served as the local health officer in Alexandria. He was a member of the Madison County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

January 13, 1946

The Council of the Indiana State Medical Association convened for its midwinter meeting at 9:10 A.M., Sunday, January 13, 1946, in Private Dining Room No. 1 of the Columbia Club, at Indianapolis, with Dr. A. M. Mitchell, of Terre Haute, chairman, presiding. Roll call showed the following present:

Members of the Council:

First District	I. C. Barclay, Evansville
Second District	Not represented
Third District	A. P. Hauss, New Albany
Fourth District	Not represented
Fifth District	A. M. Mitchell, Terre Haute
Sixth District	W. U. Kennedy, New Castle
Seventh District	C. J. Clark, Indianapolis
Eighth District	E. H. Clauser, Muncie
Ninth District	Wemple Dodds, Crawfordsville
Tenth District	Not represented
Eleventh District	C. S. Black, Warren
Twelfth District	A. Jerome Sparks, Fort Wayne
Thirteenth District	Alfred Ellison, South Bend

Officers:

J. E. Ferrell, Fortville, president.
Floyd T. Romberger, Lafayette, president-elect.
A. F. Weyerbacher, Indianapolis, treasurer.
C. A. Nafe, Indianapolis, chairman, Executive Committee.
C. H. McCaskey, Indianapolis, member, Executive Committee.
Albert Stump, Indianapolis, attorney.
T. A. Hendricks, executive secretary.
Ray E. Smith, assistant executive secretary.

Legislative Committee:

Norman M. Beatty, Indianapolis, J. William Wright, Indianapolis } co-chairmen.
F. S. Crockett, Lafayette, chairman, Committee on Rural Medical Service, American Medical Association.

On motion of Dr. Sparks, seconded by Dr. Dodds, the minutes of the Council meetings held at French Lick on November 6 and November 8, and in Indianapolis on December 16, 1945, were approved as printed in the December, 1945, and January, 1946, issues of THE JOURNAL.

The councilors had no reports to make on district activities.

District meetings were reported scheduled as follows for 1946:

Third District	May 22, Bedford
Sixth District	May 16, Brookville
Eleventh District	May 15, Peru
Twelfth District	February 26, Fort Wayne

The executive secretary called attention to the dates set for the annual session of the American Medical Association, which are July 1 to 5, 1946. The meeting is to be held at San Francisco.

In connection with district meetings, Dr. Ellison said that the Thirteenth District had adopted the policy of holding the district meeting in conjunction with the St. Joseph County Medical Society meeting. This has led to larger attendance and the procurement of better program talent.

REPORTS OF OFFICERS

Dr. J. E. Ferrell, president 1946: Everything is moving along very nicely. I am highly encouraged with the reception the men have given their appointments to the various committees, and I feel that we are in for a very good year. Of course, there are many problems that are very hard to solve, but with your cooperation I think we will be able to solve them and carry on as last year, which was a banner year. It just takes the cooperation of every man in the association. The more I get into the association work, the more responsibility I find. I feel that there is a lack of enthusiasm among the servicemen. After all, these are critical times for medicine, and we must have the cooperation of everyone, especially these younger men. I think that a publicity campaign, more or less to these men, would be a great help. We must all put our shoulder to the wheel and help them as much as possible.

Dr. A. F. Weyerbacher, treasurer, reported that some of the highest interest-bearing bonds held by the association will be called in 1946. The interest rate on holdings in the General Fund at the present time averages 3.15 per cent, while the rate on holdings in the Medical Defense Fund averages 2.91 per cent, giving an average return of 3.03 per cent.

Dr. Weyerbacher stated that the report of the certified public accountants, Geo. S. Olive & Co., was not yet completed, but would be ready for publication in the minutes of this meeting. This report follows:

TREASURER'S REPORT

January 11, 1946.

The Council,
Indiana State Medical Association.

Gentlemen:

We have examined the cash records of your Association for the year ended December 31, 1945. This examination was undertaken for the purpose of determining and verifying the cash transactions for the year, and of verifying the assets and liabilities at the close of the year, as recorded on the records.

The results of our examination are presented in this report, which includes: (1) text of comments; (2) statement of assets of all funds at December 31, 1945; (3) statements of receipts and disbursements of all funds, year ended December 31, 1945. A list of the statements is presented on the first page following this text.

General Comment

In Exhibit A is presented an analysis of the increase in assets of the Association for the year ended December 31, 1945, showing in summary form the sources from which this increase was derived.

The increase of $6,705.98 is attributable to an excess of operating cash receipts over operating cash disbursements of the General Fund, THE JOURNAL of the Indiana State Medical Association, and the Medical Defense Fund.

During the period under review, a $2,000 loan was repaid to the Medical Defense Fund from the General Fund. A similar loan of $3,000 due the Medical Defense Fund from THE JOURNAL of The Indiana State Medical Association has been cleared by permanent transfer to THE JOURNAL account.

Details of the assets of all funds are presented in Exhibit B. There were no recorded liabilities at December 31, 1945, and the assets shown represent the surplus of each fund at that date. We have examined securities of the Association, and confirmed bank balances by direct correspondence with the depositories.

Details of the cash receipts and disbursements of the General Fund, of THE JOURNAL of the Indiana State Medical Association, and of the Medical Defense Fund are presented in Exhibits C, D and E.

Yours very truly,

GEO. S. OLIVE & CO.,
Certified Public Accountants.

Indiana State Medical Association

LIST OF STATEMENTS CONTAINED IN REPORT ON EXAMINATION OF CASH RECORDS, YEAR ENDED DECEMBER 31, 1945

Exhibit A—Analysis of Increase in assets, all funds, year ended December 31, 1945.

Exhibit B—Statement of assets, all funds, at December 31, 1945.

Exhibit C—Comparative statement of cash receipts and disbursements, years ended December 31, 1944, and December 31, 1945.

Exhibit D—Statement of cash receipts and disbursements of THE JOURNAL of the Indiana State Medical Association, year ended December 31, 1945.

Exhibit E—Statement of cash receipts and disbursements of the Medical Defense Fund, year ended December 31, 1945.

EXHIBIT A

Indiana State Medical Association

ANALYSIS OF INCREASE IN ASSETS, ALL FUNDS, YEAR ENDED DECEMBER 31, 1945

TOTAL ASSETS, DECEMBER 31, 1945—Exhibit B		$51,797.93
TOTAL ASSETS, DECEMBER 31, 1944		45,091.95
NET INCREASE		$ 6,705.98
Arising from the following sources:		
Excess of operating cash receipts over operating cash disbursements, General Fund, year ended December 31, 1945:		
Receipts—Exhibit C	$42,188.98	
Disbursements—Exhibit C	39,625.97	
	$ 2,563.01	
Less: Repayment of loan to Medical Defense Fund	2,000.00	
		$ 563.01
Excess of operating cash receipts over operating cash disbursements, THE JOURNAL of the Indiana State Medical Association, year ended December 31, 1945:		
Receipts—Exhibit D	$29,336.87	
Disbursements—Exhibit D	26,167.90	
		3,168.97
Excess of operating cash receipts over operating cash disbursements, Medical Defense Fund, year ended December 31, 1945:		
Receipts—Exhibit E	$ 2,789.00	
Disbursements—Exhibit E	1,815.00	
	$ 974.00	
Add: Receipt of repayment of loan from General Fund	2,000.00	
		2,974.00
TOTAL NET INCREASE		$ 6,705.98

EXHIBIT B

Indiana State Medical Association

STATEMENT OF ASSETS, ALL FUNDS, AT DECEMBER 31, 1945

General Fund:			
Cash on deposit—Exhibit C			$ 1,028.92
Petty cash fund			200.00
Investments:			
Marion County Flood Prevention bonds	$ 3,000.00		
Indianapolis City Hospital bonds	5,000.00		
U. S. Treasury bonds	13,000.00		
U. S. Savings bonds	5,000.00		
		26,000.00	
Total General Fund			$27,228.92
THE JOURNAL of the Indiana State Medical Association:			
Cash on deposit—Exhibit D			$ 6,063.29
Total JOURNAL assets			6,063.29
Medical Defense Fund:			
Cash on deposit—Exhibit E			$ 3,505.72
Investments:			
Marion County Flood Prevention bonds	$ 2,000.00		
U. S. Treasury bonds	5,000.00		
U. S. Savings bonds	5,000.00		
U. S. Baby bonds	3,000.00		
		15,000.00	
Total Medical Defense Fund			18,505.72
Total Assets, All Funds—Exhibit A			$51,797.93

EXHIBIT C

Indiana State Medical Association

COMPARATIVE STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEARS ENDED DECEMBER 31, 1945, AND DECEMBER 31, 1944

	Year Ended December 31, 1945	December 31, 1944	Increase Decrease
CASH BALANCE AT BEGINNING OF YEAR	$ 465.91	$ 5,131.81	$ 4,665.90
Receipts:			
Membership dues	33,603.00	23,288.50	10,314.50
Income from exhibits	5,695.00	7,575.00	1,880.00
Petty cash refund—contra	500.00		500.00
Miscellaneous refunds	56.02	3.30	52.72
Interest income:			
U. S. Treasury bonds	368.75	368.75	
U. S. Savings bonds	125.00	125.00	
Indianapolis, Indiana, City Hospital bonds	200.00	200.00	
Marion County, Indiana, Flood Prevention bonds	127.50	127.50	
Instruction courses — annual session		145.00	145.00
Refund on convention expense	69.56	193.72	124.16
Industrial health conference		60.00	60.00
Funds transferred from Medical Defense Fund		2,000.00	2,000.00
Reimbursements from American Medical Association	194.15		194.15
Check for Dunninger fee	1,250.00		1,250.00
	$42,188.98	$34,086.77	$ 8,102.21
BEGINNING BALANCE PLUS CASH RECEIPTS	$42,654.89	$39,218.58	$ 3,436.31
Disbursements:			
Transfer of applicable portion of dues to THE JOURNAL of the Indiana State Medical Association — Exhibit D	$ 6,726.00	$ 6,768.00	$ 42.00
Medical Defense Fund—Exhibit E	2,439.00	2,460.00	21.00
Headquarters' office expense	11,384.80	12,564.95	1,180.15
Publicity committee	2,476.37	2,051.00	425.37
Public policy	1,403.74	283.27	1,120.47
Council	6,267.24	6,241.36	25.88
Officers	496.75	313.39	183.36
Annual session	4,750.98	4,957.20	206.22
Miscellaneous committees	2,353.95	2,882.11	528.16
Federal Old Age Benefit Tax	93.39	76.39	17.00
Refund of dues	36.75	30.00	6.75
Petty cash refund—contra	500.00		500.00
National Conference on Medical Service expense	147.59		147.59
Refund of exhibit rent	340.00		340.00
Other refunds		25.00	25.00
Instructional course expense		100.00	100.00
Payments for American Medical Association	194.15		194.15
Miscellaneous expense	15.26		15.26
Funds transferred to Medical Defense Fund	2,000.00		2,000.00
	$41,625.97	$38,752.67	$ 2,873.30
CASH BALANCE AT END OF YEAR	$ 1,028.92	$ 465.91	$ 563.01

EXHIBIT D

Indiana State Medical Association

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEAR ENDED DECEMBER 31, 1945

THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

BALANCE, JANUARY 1, 1945		$ 2,894.32
Receipts:		
Subscriptions—members—Exhibit C	$ 6,726.00	
Subscriptions—non-members	461.92	
Advertising	21,985.45	
Collection on accounts receivable	47.00	
Single copy sales	50.85	
Electrotypes	65.65	
Total receipts—Exhibit A		29,336.87
		$32,231.19
Disbursements:		
Salaries	$10,498.47	
Printing	12,042.36	
Office postage	333.42	
Journal postage	501.14	
Press clippings	68.10	
Telephone and telegraph	257.97	
Electrotypes	737.80	
Office rent and electricity	515.93	
Office supplies	575.61	
Advertising commissions and reporting	546.14	
Federal Old Age Benefits Tax	75.30	
Miscellaneous	15.66	
Total disbursements—Exhibit A		26,167.90
BALANCE, DECEMBER 31, 1945—EXHIBIT B		$ 6,063.29

EXHIBIT E

Indiana State Medical Association

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEAR ENDED DECEMBER 31, 1945

MEDICAL DEFENSE FUND

BALANCE, JANUARY 1, 1945		$ 531.72
Receipts:		
Transfer of applicable portion of dues from the General Fund—Exhibit C	$ 2,439.00	
Interest income:		
U. S. Treasury bonds	140.00	
U. S. Savings bonds	125.00	
Marion County Flood Prevention bonds	85.00	
Funds transferred from General Fund	2,000.00	
Total receipts—Exhibit A		4,789.00
		$ 5,320.72
Disbursements:		
Attorney's fee	$ 1,800.00	
Treasurer's bond	15.00	
Total disbursements—Exhibit A		1,815.00
BALANCE, DECEMBER 31, 1945—Exhibit B		$ 3,505.72

Dr. Cleon A. Nafe, chairman of the Executive Committee, discussed the distribution of 8,000 units of Red Cross plasma, which is to be a duty of the State Board of Health. Rules of the Red Cross are that there be no charge for this plasma and that it be distributed in Indiana where it will be used and where it will be given without cost. That does not interfere, however, with an administration charge. The State Board of Health has suggested that this plasma be distributed to hospitals that want it, according to the bed capacity. Dr. Nafe asked if it would meet with the approval of the Council if this plasma were distributed to the hospitals on the basis of bed capacity, the needs of the community, according to population, at the request of the hospitals. It was taken by consent that this plasma should be made available without charge to any doctor, any hospital, or any community in need thereof.

Upon the motion of Dr. Ellison, seconded by Dr. Barclay and Dr. Sparks, the salary of Ray E.

Smith, part-time assistant executive secretary, was raised from $3,000 to $3,500 per year.

SUGGESTIONS AND PROPOSALS FOR 1946 (97TH) ANNUAL SESSION AT FORT WAYNE

(1) Dr. Clark made the motion that instructional courses be given at Fort Wayne. Dr. Ellison, in seconding the motion, said he felt that these courses should be emphasized as a major part of this year's meeting. Motion carried. It was taken by consent that a local committee should take the responsibility of arranging for these courses.

(2) It was taken by consent that a golf tournament, skeet and trap shoot be held.

(3) It was agreed to have sectional meetings on Wednesday afternoon.

(4) Dr. Clark made the motion that the Thursday morning scientific meeting be discontinued. Motion seconded by Dr. Barclay, and passed.

(5) *Fort Wayne hotel situation.* Dr. Sparks reported that the Fort Wayne Medical Society had the promise of four hundred rooms, or 50 per cent of the accommodations available in the three principal hotels, for the session. Discussion by Drs. Ellison, Dodds, Hauss, and Barclay resulted in the motion by Dr. Clark that the 1946 annual session be held in Indianapolis. Dr. Ellison seconded this motion, and it was passed.

It was taken by consent that the Executive Committee is to take this matter up with the Indianapolis Medical Society at its next meeting and get preliminary details worked out.

(6) The dates for the Indianapolis meeting are to be set after conferring with the Indianapolis Convention Bureau.

(7) Dr. Clark moved that a scientific exhibit should be held in connection with the 1946 annual session; seconded by Dr. Ellison, and passed.

(8) Dr. Clark moved that professional medical stenographers be employed; seconded by Dr. Ellison, and carried.

(9) General outline of program follows:

Monday—October 28, 1946

Meeting of health officers.

Tuesday—October 29, 1946

Morning	Registration.
	Instructional courses.
	Commercial Exhibit.
	Annual golf tournament.
	Skeet and trap shoot.
Afternoon	Council meeting.
	Meeting of House of Delegates.
	Instructional courses.
Evening	Smoker and stag party.
	Dinner for women physicians.

Wednesday—October 30, 1946

Morning	General scientific meeting.
Noon	Class and fraternity get-togethers and luncheons.
	Veterans' luncheon.
Afternoon	Section meetings.
Evening	Annual dinner.

Thursday—October 31, 1946

Morning	Final meeting of House of Delegates.
	Final Council meeting.

MEMBERSHIP PROBLEMS

1. *Membership report.*

MEMBERSHIP REPORT

Indiana State Medical Association

December 31, 1945

County Society	No. M.D.'s in County	Members Dec. 31, 1945	Members Dec. 31, 1944	Loss — Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
1st District									
Posey	15	12	13	—1	1		2		
Vanderburgh	200	162	158	4	22	7	15	2	4
Warrick	19	13	12	1	1	1	4	1	
Spencer	16	10	11	—1	3		2	1	
Perry	12	11	10	1					1
Gibson	26	26	25	1		1			
Pike	13	12	8	4		1	1		
Total	301	246	237	9	27	10	24	4	5
2nd District									
*Knox	50	41	41		4		6	1	1
Daviess-Martin	30	23	24	—1	5		1	1	
Sullivan	25	21	22	—1			5	2	
Greene	22	20	19	1	2	1			
Owen	11	10	11	—1				1	
Monroe	36	35	34	1	1				
Total	174	150	151	—1	12	1	12	5	1
3rd District									
Lawrence	25	20	21	—1	1		4		
Orange	14	13	13		1		3	1	
Crawford	7	6	6				1		
Washington	12	12	11	1		1	1	1	
Scott	8	4	5	—1	2		2		
Clark	33	21	21		9		1	1	1
*Floyd	45	39	38	1	2	2	1	3	1
Harrison	10	10	8	2		2		1	
Dubois	18	17	17		1		1		
Total	172	142	140	2	16	5	14	7	2
4th District									
Brown	1				1				
*Bartholomew	35	28	30	—2	1		3	1	3
*Decatur	18	16	16				2		
Jackson	19	18	17	1			1		
*Jennings	11	11	12	—1			1	1	
*Ripley	14	13	13		1			1	
Jefferson	23	19	17	2	2		3	1	
Switzerland	6	5	5		1				
*Dearborn-Ohio	20	18	19	—1					2
Total	147	128	129	—1	6		10	4	5
5th District									
Parke-Vermillion	36	26	29	—3	6		5		1
Putnam	22	19	19		1		1	1	2
Vigo	115	101	103	—2	6	1	8	1	5
Clay	17	17	16	1		1	1		
Total	190	163	167	—4	13	2	15	2	8

County Society	No. M.D.'s in* County	Members Dec. 31, 1945	Members Dec. 31, 1944	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
6th District									
Hancock	27	26	26				1		
*Henry	41	38	37	1	2		3		1
*Wayne-Union	73	62	62		5		4	1	3
Rush	14	14	14						
Fayette-Franklin	22	18	19	—1	1		1		2
Shelby	31	26	28	—2	1		4		
Total	208	184	186	—2	9		13	1	6
7th District									
Hendricks	19	17	18	—1			1	1	1
*Marion	877	726	726		95	34	30	19	25
Morgan	30	20	22	—2	4		4	2	1
*Johnson	19	14	15	—1	2		1	3	
Total	945	777	781	—4	101	34	36	25	27
8th District									
*Madison	96	82	85	—3	2	3	5	4	3
*Delaware-Blkfd.	110	88	84	4	17	10	5		3
Jay	25	21	22	—1	2		2	1	
Randolph	25	23	23		1		1	1	
Total	256	214	214		22	13	13	6	6
9th District									
Benton	9	9	10	—1					
*Fountain-Warren	22	20	18	2	1		2		
*Tippecanoe	98	96	89	7		5	2	1	
*Montgomery	35	31	30	1	1		5	1	
Clinton	25	23	22	1			2		
Tipton	16	12	11	1	1		3		
Boone	24	18	21	—3	5		1		
Hamilton	27	21	21		1		2	2	1
White	7	3	4	—1	4				
Total	263	233	226	7	13	5	17	4	1
10th District									
Lake	290	248	249	—1	28	10	15	6	3
Porter	29	26	28	—2	1		4	1	
Jasper-Newton	21	16	16		3	1	1	1	
Total	340	290	293	—3	32	11	20	8	3
11th District									
Carroll	14	13	13			1	1		
*Cass	50	40	39	1	3	2	5	1	1
*Miami	27	22	22			1		3	2
*Wabash	29	22	25	—3	3	1	4	1	
*Huntington	27	26	27	—1				1	1
*Howard	45	37	38	—1	2	1	3	1	2
Grant	60	47	49	—2	5	2	4	6	1
Total	252	207	213	—6	13	8	17	13	7
12th District									
LaGrange	5	5	5						
Steuben	18	11	12	—1	5		1	2	
*Noble	25	25	25				1	1	
DeKalb	26	22	22		2		2		
Whitley	16	12	12				2	1	3
Allen	203	176	175	1	9	4	10	4	12
*Wells	24	21	21			2	3		
*Adams	24	20	21	—1	2		1	1	2
Total	341	292	293	—1	18	6	20	9	17

County Society	No. M.D.'s in* County	Members Dec. 31, 1945	Members Dec. 31, 1944	Loss—Gain	Eligible Non-Members	New Members	Removed and Retired	Deceased	Ineligible
13th District									
*LaPorte	73	65	67	—2	5	3	4	3	
*St. Joseph	194	170	166	4	10	6	14	2	5
*Elkhart	84	72	73	—1	1	2	10	3	1
Starke	4	4	4						
Pulaski	8	7	8	—1	1				
Fulton	16	13	12	1	1		1	2	
Marshall	29	25	24	1		1		2	3
Kosciusko	21	10	17	—7	8		2	1	
Total	429	366	371	5	26	12	31	13	9
Summary by Districts									
1st District	301	246	237	9	27	10	24	4	5
2nd District	174	150	151	—1	12	1	12	5	1
3rd District	172	142	140	2	16	5	14	7	2
4th District	147	128	129	—1	6		10	4	5
5th District	190	163	167	—4	13	2	15	2	8
6th District	208	184	186	—2	9		13	1	6
7th District	945	777	781	—4	101	34	36	25	27
8th District	256	214	214		22	13	13	6	6
9th District	263	233	226	7	13	5	17	4	1
10th District	340	290	293	—3	32	11	20	8	3
11th District	252	207	213	—6	13	8	17	13	7
12th District	341	292	293	—1	18	6	20	9	17
13th District	429	366	371	5	26	12	31	13	9
Total	4018	3392	3401	—9	308	107	242	101	97

** Physicians are listed in the counties in which they hold membership; not in the counties in which they reside.*

1,029 physicians received membership gratis in 1945 because of military service.

(2) It was taken by consent that Dr. Overpeck, councilor of the Fourth District, should make an effort to incorporate Brown County, the only county in the state not organized, with the Bartholomew or the Monroe County Medical Society.

(3) Dr. Mitchell said he would try to get the Parke-Vermillion County Medical Society organized and functioning again.

(4) Dr. Sparks brought to the attention of the Council the matter of a physician in his district who has been appointed as a member of the Governor's Hospital Council who is not a member of his county medical society. As the situation exists, he cannot become a member of his local county society, and he asks that he be allowed to belong to an adjoining county society. According to the By-Laws he must have permission of his local county society to affiliate with the adjoining society. Thus, the matter becomes a problem of the Council.

Dr. Ellison made the motion that in order that the Council may have some information on which to act, this local society be asked to submit to the Council the facts as it sees them in this case. This motion was seconded by Dr. Clark, and passed.

STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION

It was announced that a hearing on the Osteopathic Bill, which was passed at the 1945 legislature, is to be held Thursday, January 24. Mr.

Stump, attorney for the association, reported that he had prepared a brief upon this bill.

Dr. Ellison made the motion that additional legal talent be employed to represent the medical profession at this meeting on January 24. This motion was seconded by Dr. Clark, but was lost on a voice vote.

PREPAYMENT MEDICAL CARE INSURANCE

Dr. Kennedy summarized the previous actions of his committee and the Council, adding that "the insistence about getting into motion seems to be growing greater. We must get into action. The only way we are going to find the right way is to start out as nearly the right way as we can, and then make changes as we go along."

At this point the chairman read the minutes of the December 16, 1945, meeting of the Council, which follow:

> "Dr. Black made the following motion: 'I move that we adopt the agency-type indemnity plan and submit it to the House of Delegates for its approval, with the option of selecting a mutual indemnity plan.' This motion was seconded by Dr. Overpeck, and carried.
>
> "Dr. Howard made the motion 'that Dr. Kennedy write a simple-language letter on this proposition, specifically stating that the state association is in no way financially bound by this proposition, and send it to every delegate in the state.' Motion duly seconded, and carried."

Dr. Sparks asked that the action taken by the Council at the December 16 meeting be reconsidered, saying, "Most of the states are going in for voluntary plans, operated by themselves. This is *our* problem, and I believe that we can do a better job than an intermediary doing it for us. I think that the people will be better satisfied. I feel that we should recommend to the House of Delegates a single plan—that we operate our own mutual indemnity company."

Dr. Clark stated that his thoughts at this time were in direct reversal of his opinion at the time of the last Council meeting. Following discussion, Dr. Clark made the motion that the Council present its recommendations to the House of Delegates as being in favor of the mutual indemnity plan, non-profit. This motion was seconded by Dr. Sparks, and passed.

Mr. Hendricks stated that no definite action will be taken by the American Medical Association by January 27, the date set for the special meeting of the House of Delegates to consider this matter.

It was suggested that copies of the outline of articles of incorporation for a mutual company be sent to members of the House of Delegates.

Dr. Hauss spoke in favor of the service plan, saying, if a plan is to reach all of the people it must be a service type plan.

It was taken by consent that the meeting of the House of Delegates should be held as scheduled on January 27, 1946.

ECONOMIC AND ORGANIZATION MATTERS

(1) Action of the Utah State Medical Association on the EMIC Program was brought to the attention of the Council.

(2) *Indiana Inter-Professional Health Council.* Upon the motion of Dr. Barclay, seconded by Dr. Sparks, Dr. Mitchell appointed Dr. E. H. Clauser, chairman, and Dr. A. P. Hauss a member of the Inter-Professional Health Council for 1946.

(3) *Building Committee.* Dr. Walter Kelly of Indianapolis appeared before the Council on behalf of Dr. Bert Ellis, chairman of the Building Committee of the Indianapolis Medical Society. He reported that the Indianapolis (Marion County) Medical Society is planning on constructing a $300,000 society building. He said that whether or not the state association wishes to join in the project is up to the Council.

Dr. Clark made the motion that the state association join with the Indianapolis Medical Society in forming plans for a society home. This motion was seconded by Dr. Black, and passed.

(Dr. Ferrell, president, later appointed the following Building Committee for the state association: Paul A. Garber, South Whitley, chairman; Oran Province, Franklin; and Minor Miller, Evansville. These members are to be asked to meet with the Indianapolis Medical Society Building Committee and report to the Council at its next meeting).

(4) *Constitution Committee.* The recommendation of the Committee for the Study of Lay Activity in Medical Practice was considered by the Council, and it was agreed that a Constitution Committee should be appointed.

(6) Question of relationship of the medical profession with osteopaths was brought to the attention of the Council by a letter received from the secretary of a county medical society. This was discussed by Dr. Romberger and Dr. Kennedy, and they were directed to communicate with the county society secretary.

(7) *Cancer clinics.* This matter was referred to the Council by the House of Delegates at its November 8, 1945, meeting. The president of the association is to appoint a Cancer Committee, and this committee is to report back to the next Council meeting.

NEW BUSINESS

(1) *Contract with the Editor of* THE JOURNAL signed by Dr. Mitchell, chairman of the Council.

(2) *Nominations for Editorial Board:*

Dr. Barclay nominated Dr. Pierce MacKenzie, Evansville.

Additional nominations are to be made at the next Council meeting.

(3) *Council district maps.* Dr. Clark moved that a large map (approximately 17" x 22"), showing the councilor districts, be prepared and sent to each councilor. Motion seconded by Dr. Kennedy, and carried.

(4) *American Social Hygiene Day, February 18, 1946.* Letter received from Dr. George Bowman, director of Venereal Disease Control, Indiana State Board of Health, read to the Council. Dr. Hauss moved that the Council endorse the idea of sponsoring National Social Hygiene Day if it receives

the approval of the local county medical society in every city in which it is to be held. This motion was seconded by Dr. Ellison, and passed.

(5) *Need for Veterans Administration medical personnel.* Letter from Colonel H. H. Botts, M.C., manager of the Veterans Administration at Marion, Indiana, read to the Council. It was taken by consent that a copy of this letter should be sent to each county medical society secretary and also published in THE JOURNAL.

(6) *Presentation of insurance problem to House of Delegates.* Dr. Ellison moved that Dr. Kennedy be delegated by the Council to present the Council committee's decision on prepayment insurance to the House of Delegates on January 27. This motion was seconded by Dr. Clauser, and passed.

(7) *Letter from Dr. Wadsworth.* The executive secretary read a letter received from Dr. H. C. Wadsworth, former councilor of the Second District, suggesting that the Council meeting which is held in January, and also the Secretaries' Conference, be held early in May when weather conditions are more desirable for traveling. A copy of this letter is to be sent to each councilor.

(8) *April meeting of Council.* Dr. Barclay moved that the next meeting of the Council be held on April 14, 1946. Taken by consent.

ELECTIONS FOR 1946

(1) *Executive Committee members.* Upon the motion of Dr. Clark, seconded unanimously, Dr. C. A. Nafe and Dr. C. H. McCaskey were re-elected members of the Executive Committee for 1946.

(2) *Chairman of the Council.* Upon the motion of Dr. Clark, seconded by Dr. Black, Dr. A. M. Mitchell was re-elected chairman of the Council for 1946.

There being no further business, the meeting was adjourned.

THOMAS A. HENDRICKS,
Executive Secretary.

COUNCIL

January 27, 1946

A special meeting of the Council was held in the East Room of the War Memorial, in Indianapolis, on January 27, 1946; the chairman, Dr. A. M. Mitchell, of Terre Haute, presiding.

Roll call showed the following members present:

Councilors:

Third District—A. P. Hauss, New Albany
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—William H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne

Officers:

J. E. Ferrell, Fortville, president.

Members of Executive Committee:

Cleon A. Nafe, Indianapolis, chairman.
Albert Stump, Indianapolis, attorney.
T. A. Hendricks, executive secretary.
Ray E. Smith, assistant executive secretary.

DR. MITCHELL: This meeting is for the consideration of the Board of Directors to operate this insurance company, and it says in the resolution that there should be seven or more directors. My understanding is that twelve is the proper number.

MR. STUMP: It can be incorporated with seven or more.

DR. CLARK: Since this is to be an effort of the Indiana State Medical Association, and since it is to be state-wide in scope, and we want to convince the general practitioner that his particular area is thoroughly represented, I see no reason why it would not be a good idea to make the entire membership of the Council directors of the organization. That is as nearly a representative group, under the control of the county societies and various districts, as any group I can think of.

(Dr. Howard seconded the motion.)

DR. MITCHELL: It has been moved and seconded that all members of the Council be added to this Board of Directors; that the Council be the incorporators or Board of Directors. All in favor, say "Aye."

DR. KENNEDY: I do not like the notion of making the Council the Board of Directors. I have no objection to the members of the Council being on the Board of Directors, but that is going to limit us. You may want men of special business ability on the Board of Directors. I will go along with you on that provided it is made wide enough to permit additional men to come on it.

DR. CLARK: I mean the incorporators.

MR. STUMP: We can take care of that in this manner: First, we need a list of people who will be the incorporators. They have to sign the articles of incorporation. We have to announce who will be the first Board of Directors. They are expected to serve to the end of this appointment, that is, to the first annual meeting. But in the meantime your By-Laws, which will be adopted by the first Board of Directors, may provide for as many as you want, and those places can be filled under conditions written into the By-laws by the original Board of Directors. There are thirteen incorporators, and if you want thirty-five directors, you would have twenty-two places left, and provision could be made in the By-laws for the filling of the twenty-two places. That could be done immediately, and they could qualify under the By-laws and not under the Articles.

DR. HAUSS: As I remember this, the resolution states that this committee is to be appointed by the president of the Association, with the approval of the Council. Can the Council vote on this motion now, when the committee has not even been appointed. There is another thing; there are several men that probably know as much about insurance affairs as Dr. Kennedy. No one knows more than

he does, but these men would be valuable men on this committee, and they are not members of the Council, so I think the only thing we can do is for the chairman to submit his committee, or appoint his committee, and then for the Council to approve it.

DR. SPARKS: I think that Dr. Clark is right about this. We want to get going right now, and this group is already organized and familiar with the problems. In the meantime we can think of men to add to the Board of Directors, as Mr. Stump pointed out, at the next meeting or when the time is appropriate for that.

DR. MITCHELL: Dr. Ferrell has named as a committee, for the approval of the Council, the following:

M. A. Austin, Anderson.
I. C. Barclay, Evansville.
C. S. Black, Warren.
Cyrus J. Clark, Indianapolis.
E. H. Clauser, Muncie.
F. S. Crockett, Lafayette.
James H. Crowder, Sullivan.
Wemple Dodds, Crawfordsville.
Alfred Ellison, South Bend.
J. E. Ferrell, Fortville.
A. P. Hauss, New Albany.
William H. Howard, Hammond.
W. U. Kennedy, New Castle.
M. R. Lohman, Fort Wayne.
A. M. Mitchell, Terre Haute.
C. F. Overpeck, Greensburg.
Walter L. Portteus, Franklin.
F. T. Romberger, Lafayette.
A. Jerome Sparks, Fort Wayne.

DR. CLARK: I move that we approve this committee. (Motion seconded by Dr. Sparks, and carried.)

DR. MITCHELL: After the first Board of Directors has had a meeting, you are going to take in a representative of labor, a representative from the manufacturers, and several others that will represent the public in carrying out the thing. I do not think that it should go as high as thirty-five directors, probably twenty-five at the most.

DR. SPARKS: Michigan has seventeen men.

DR. KENNEDY: The whole House of Delegates is a member of the Board of Directors of the company, and then they have an executive committee which conducts the business. Thirty-five is too many to agree on anything. Have a small group for specific functions if you want to get results.

MR. STUMP: If you want to start quickly, we can name them all as incorporators, but you will have no objection if we get three incorporators to sign, if that can be done by law. I think that we can handle it with three.

DR. KENNEDY: It took two months in Ohio to get the papers sent all around for signatures.

MR. STUMP: The preliminary cost, filing fees, will amount to about fifteen dollars. I think that the fees for the issuing of the permit cannot be given until after we have published our notice of intention to incorporate, and all that we need for the publication of notice to incorporate is that we have the list of incorporators. They do not have to sign the notice. An agent can do that. I will act as agent in that regard.

MR. HENDRICKS: Just two suggestions: First, I hope that this committee of incorporators will do one thing—this is probably most essential to the success of such a project as we have undertaken here today—and that is to see that you place at the head of this organization the very best insurance man you can possibly obtain. Secondly, that this organization here see that representatives from the Indiana State Medical Association (from this company if it is formed) attend a meeting of the Medical Service Plans Conference, which is to be held on February 12, at Chicago. That meeting is probably the most important meeting that the Service Plan Groups have yet had, due to the fact that the American Medical Association House of Delegates has approved an over-all national insurance program. The meeting will be at the American Medical Association headquarters, at Chicago, all day, on February 12. Recommendations adopted at that conference will come before the Council on Medical Service and Public Relations on February 13, and there will be a joint meeting of the Council with the Board of Trustees of the American Medical Association on February 14. You can see this meeting is going to be a key meeting in the whole national picture, and I think that if Indiana is starting such a project at this time it would be very much to our advantage to have as many there at the meeting as possible, so we can get this whole picture.

DR. HOWARD: Are you going to set up an Executive Committee to get this thing going today?

MR. STUMP: The procedure will be, first, to publish a notice in the newspapers. I will arrange for that tomorrow. The next thing is the preparation of the Articles of Incorporation, and those are already prepared, ready to be signed. There must be at least three who will execute these, and they can be the ones most conveniently located. That is all that is necessary to get ourselves on the way to being organized. We do not need an Executive Committee.

DR. NAFE: It seems to me that we should have a committee to raise this money. Before you start, you have to get money. It will not take long to get the Articles of Incorporation.

MR. STUMP: The notice of incorporation must stand from ten to twenty days before filing. Then at that time you can begin raising some money. You can get commitments. We can not legally take money into the corporation until we are incorporated.

DR. HAUSS: I think the main thing from now on is that this be definitely piloted, with a definite head, and I would like to move that Dr. Kennedy be made temporary chairman of the Board of Directors of the Mutual Medical Insurance Company.

Then he can direct this work in the proper sequence, and I think it will move along faster.

(Motion seconded by Dr. Clark, and carried.)

DR. MITCHELL: Is nothing to be done in regard to finances until after the corporation?

MR. STUMP: Unless, in the interest of time, you care to name someone to hold funds until the corporation is completed, which will take ten to twenty days. Either an individual or a bank could be named.

DR. CLARK: I move that we name the Treasurer of the Indiana State Medical Association to hold these funds as an individual. (Motion seconded by Dr. Black, and carried.)

MR. STUMP: There should be a trust agreement signed by him, and we will prepare that agreement.

DR. SPARKS: Is it the plan to canvass the membership generally?

DR. KENNEDY: I think that a general solicitation of every member of the state should be made.

DR. NAFE: What figure are you going to accept as the top? You do not want any one person to feel that he has too much in this thing.

DR. KENNEDY: They can make subscriptions, and then you can cut them down—pro-rate them. Most of the replies I received suggested that they were willing to advance $1,000.00, and some $1,500.00. One man had $5,000.00 he said he would invest. The more men you have, the better.

(Here quite a discussion followed as to the amount allowed to be subscribed—with no definite amount settled upon.)

DR. MITCHELL: Is there any action you want to take on Dr. Giordano's recommendation?

(After some discussion at this point, Dr. Mitchell suggested that a committee of three be appointed to confer with General Hawley, and report back to a Council meeting, then put it up to the county medical societies. The following committee was appointed: Charles F. Thompson, Indianapolis; A. S. Giordano, South Bend; and William H. Garner, New Albany.)

Meeting adjourned at 3:30 P.M., to meet again on April 14, 1946.

HOUSE OF DELEGATES

January 27, 1946

The meeting of the House of Delegates, held in the East Room of the War Memorial, Indianapolis, on January 27, 1946, convened at 1:20 P.M.; the president, Dr. J. E. Ferrell, of Fortville, presiding.

DR. FERRELL: How many delegates are new members and have not had this situation explained to them? Please stand up. (Seven new delegates stood up.)

DR. FERRELL: Dr. Amy, chairman of the Credentials Committee, is there a quorum present?

DR. AMY: There is.

DR. FERRELL: The blanks that you signed at the door will substitute for roll call.

These slips showed the following members present:

DELEGATES

County	*Delegates*
Adams	Ben Duke, Berne.
Allen	M. B. Catlett, Fort Wayne.
	William Wright, Fort Wayne.
	M. R. Lohman, Fort Wayne.
Bartholomew	Joseph Dudding, Hope.
	Lowell F. Beggs, Columbus (Alternate)
Carroll	Max Adams, Flora.
Cass	E. B. Jewell, Logansport.
Clay	J. Frank Maurer, Brazil.
Clinton	F. A. Beardsley, Frankfort.
Daviess-Martin	C. P. Fox, Washington.
Dearborn-Ohio	M. J. McNeely, Dillsboro.
DeKalb	Russell P. Reynolds, Garrett.
Delaware-Blackford	C. A. Ball, Muncie.
	B. W. Stocking, Muncie.
Elkhart	A. C. Yoder, Goshen.
Fayette-Franklin	F. B. Mountain, Connersville.
Floyd	William Garner, New Albany.
Fulton	A. E. Stinson, Rochester.
Grant	R. W. Lavengood, Marion.
Hamilton	C. M. Donahue, Carmel.
Hancock	Joseph L. Allen, Greenfield.
Harrison	William E. Amy, Corydon.
Hendricks	O. T. Scamahorn, Pittsboro.
Henry	C. E. Canaday, New Castle.
Howard	E. R. Clarke, Kokomo.
Huntington	C. M. Nie, Huntington.
Jasper-Newton	W. G. Pippenger, Brook.
Jay	George Cring, Portland.
Johnson	Oran Province, Franklin.
Knox	C. L. Boyd, Vincennes.
Lake	H. W. Eggers, Hammond.
	J. R. Doty, Gary.
	C. M. Jones, Whiting.
Madison	A. T. Jones, Pendleton.
	C. V. Rozelle, Anderson.
Marion	Eugene F. Boggs, Indianapolis.
	Raymond C. Beeler, Indianapolis.
	George J. Garceau, Indianapolis.
	Harry L. Foreman, Indianapolis.
	John M. Whitehead, Indianapolis.
	Bert E. Ellis, Indianapolis.
	Marlow W. Manion, Indianapolis.
	Foster J. Hudson, Indianapolis.
	James F. Balch, Indianapolis.
	Charles F. Thompson, Indianapolis.
	Clyde G. Culbertson, Indianapolis.
	Cleon A. Nafe, Indianapolis.
	Roy A. Geider, Indianapolis.
	William M. Dugan, Indianapolis (Alternate).
Miami	F. M. Lynn, Peru.
Monroe	Naomi Dalton, Bloomington.
Morgan	R. W. Van Bokkelen, Mooresville.
Owen	Oran Kay, Spencer.
Parke-Vermillion	J. R. Bloomer, Rockville.
Porter	John R. Frank, Valparaiso.
Randolph	Lowell W. Painter, Winchester.
Rush	R. B. Johnson, Rushville.
St. Joseph	A. S. Giordano, South Bend.
Shelby	W. D. Inlow, Shelbyville.
Tippecanoe	O. L. McCay, Romney.
	Gordon A. Thomas, Lafayette.
Vanderburgh	Minor Miller, Evansville.
	C. C. Herzer, Evansville.
Vigo	M. C. Topping, Terre Haute.
	E. O. Nay, Terre Haute
Wabash	F. M. Whisler, Wabash.
Wayne-Union	Harry P. Ross, Richmond.
	Will A. Thompson, Liberty.
Wells	Harold D. Caylor, Bluffton.
Whitley	Paul Garber, South Whitley.

COUNCILORS

Third District—A. P. Hauss, New Albany
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—William H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne

PAST PRESIDENTS

George Daniels, Marion.
F. S. Crockett, Lafayette.
Karl Ruddell, Indianapolis.
M. A. Austin, Anderson.
C. H. McCaskey, Indianapolis.

OFFICERS

President—J. E. Ferrell, Fortville
President-elect—F. T. Romberger, Lafayette
Executive Secretary—Thomas A. Hendricks, Indianapolis
Assistant Executive Secretary—Ray E. Smith, Indianapolis
Attorney—Albert Stump, Indianapolis

DELEGATE TO A. M. A.

Don F. Cameron, Fort Wayne.

DR. FERRELL: While we are waiting for Dr. Kennedy, we have one man here that we might like to hear from, Dr. Crockett, who has just come back from Washington and who may have something to tell us. Dr. Crockett, do you have anything to say?

DR. CROCKETT: Mr. President, Gentlemen: I had the privilege last week of going to Washington on a little business for the American Medical Association. You know the Hill-Burton Bill has passed the Senate. It is now coming up before the House, and committee hearings will begin early in February. It was my duty, along with Tom Hendricks and R. L. Sensenich, to go down and contact the Administrator of the Social Security Administration. We were looking forward to the fact that if the Hill-Burton Bill was passed, the thing would become a matter of great interest to the medical profession as a whole; that the hospital facilities, the diagnostic facilities, and other facilities which were provided by the bill should be placed from a scientific standpoint, after proper survey by people qualified to make surveys, as to the element of need in the population. As you know, the bill provides that the local community will have to pay part of the construction, anywhere from 75 down to 25 per cent, according to the state to which it applies. The community must also show ability to support the facility, as well as show that it has the professional personnel available, or that it can be obtained, to keep such facility in proper order.

Now it is possible that these facilities will be tremendously valuable in solving some of the problems which rural medicine has, in particular. I happen to be interested in rural medicine, because that is my committee with the American Medical Association. We know that the farmers, as a group (and there are three groups: The Farm Bureau, the Grange, and the Farmers Union), are quite influential. The Grange and the Farm Bureau are conservative people, thinking as we do, opposed to anything in the way of compulsory legislation, especially in regard to medical treatment. They have testified before the Senate against the Wagner-Murray-Dingell Bill and bills of that type, so that it seems wise that we doctors should tie up with the Farm Bureau, not only on the federal level, but also on the state and county level, to work out with the Farm Bureau, or any other farm group, the problems that are going to come up under this Hill-Burton Bill.

The Hill-Burton Bill provides on the national level for an Advisory Council, composed of eight men, five of whom must be men conversant with hospital and professional medical treatment problems; three to represent the public. We went around to the headquarters of the Bureau. We called on Watson Miller, Administrator of the Federal Security Administration, an old Hoosier—and somewhere along, wherever you talk with these people in Government, you will find that they say, "What are you doctors planning to do?" We tell them of the states that are putting out prepayment plans, the Blue Cross Plan, and how the two are being sold together. We hope that some action will soon be taken in Indiana along this line. And then we say to them, "What about this Federal legislation; what chance does it have?" They say that there is no question in their mind but that the Hill-Burton Bill is going through, and after a while, if there is not a proper answer made by the medical profession, and those interested in a kindred way, to this need for care in catastrophic or other illness, undoubtedly there will be some Federal legislation. We know that we may get it anyway, because one can never tell, but the chances are that if we take some positive action, go ahead and intelligently get some experience, it will all contribute to a better solution; and if we do something about it ourselves we are at least getting information from a sound, doctor's standpoint, in meeting a great need which is universally acknowledged, especially outside the medical profession.

I came back very much impressed. At the House of Delegates' meeting in December we had the same thing from all over the country. The feeling was that we doctors were going to have to do something this year; do it pretty soon; and do it in such a manner as to show our friends in Congress (and we have a lot of them) that they can say on the floor of Congress: "Let the doctors alone; let the hospitals alone; they are working at this, getting experience. There is no overall experience which justifies the Wagner-Murray Bill at present, and the doctors are working it out, getting experience." If we do a forthright and earnest job we will give our friends in Congress the very argument they must have to put off and possibly defeat federal legislation of a compulsory type. (Applause.)

DR. FERRELL: Thank you, Dr. Crockett. In the interim, I believe that our Executive Committee Chairman has a few words—Dr. Nafe.

DR. NAFE: It has been suggested that I announce, or call to your attention, the fact that the nineteenth annual meeting of the National Conference on Medical Service will be held in Chicago on February tenth. That is sponsored this year by the Indiana State Medical Association. A good many years ago they changed the name from the Northwest Conference to the National Conference on Medical Service. It was formerly organized by seventeen states, and sponsored by these in rotation. We are the sponsors this year. I think that the program is very interesting, very fine, discussing many of these problems, and as many as can be in Chicago that day are welcome.

At the last meeting of the Council, just two weeks ago, the Council decided, after thorough study, that it was not possible this year, or at least wise, because of the housing situation, to have the state meeting in Fort Wayne. Therefore, as is the custom, Indianapolis is willing—not too anxious, but willing—to have the convention here. To us here it means that we have to stay at home and work, but nevertheless that was the decision of the Council, and we want to announce at this time that the Executive Committee has found that the available dates in Indianapolis, when there are no conflicts, are October 29, 30, and 31. This is a little later than usual, but that was the best, at this late date, that we could do in making arrangements for having the convention here. The Public Health Meeting will be on the 28th. The meetings will be at the Murat Temple, where we had it two or three years ago. These are the tentative arrangements.

DR. FERRELL: I think that we will just have to wait until Dr. Kennedy comes. We can not go on without Dr. Kennedy, because he is delegated by the Council to make this explanation to you.

DR. GIORDANO: Would it be out of order to consider a matter of business that is somewhat related to the thing before the House today; that is, the matter concerning the care of veterans?

DR. FERRELL: I think not, if it is agreeable with the House to hear your explanation. I do not think I need a motion. It is taken by consent.

DR. GIORDANO: At the last meeting of the House of Delegates of the American Medical Association, in December, the Monmouth County (New Jersey) Plan was presented for consideration. I do not know how many of you are familiar with it. If you would like to hear the outline of that plan, I shall be glad to read it to you, as we in St. Joseph County have modified it and presented it to General Hawley. This plan was presented to General Hawley at the last meeting of the Secretaries in Indiana, and he replied to the effect that he was very much pleased with the plan and would like to approve it, but he pointed out that there are many thousand counties in the United States, and he felt that such a plan should be approved on a state level, and that a letter was being directed to the Indiana State Medical Association to take up this question on a state level. I felt that inasmuch as the House of Delegates was meeting today, if you think well of this plan, that you may wish to direct either the Council or the Executive Committee to be instructed to do certain things; so if you wish, I shall be glad to present this plan to you for at least a hearing, and if you would ilke to take any action, the House may do so, perhaps by suspension of rules.

(Hearing taken by consent.)

(Here Dr. Giordano read the "Purpose," (A) through (F), then made this comment:

DR. GIORDANO: That more or less goes along with the problem Dr. Crockett touched upon.

(Dr. Giordano proceeded to read "Plan," (1) and (2), also the first paragraph of "Emergency Cases,"; then commented:

"General Hawley, in Chicago, stated that the Veterans Administration would take care of some non-service-connected illnesses, but not very many."

(Then, beginning with the last paragraph, he finished reading the paper.)

The Purpose and Plan are as follows:

ST. JOSEPH COUNTY (INDIANA) PLAN FOR MEDICAL CARE OF VETERANS

Purpose:

To provide the same facilities for medical care to the veterans that other citizens have, in addition to special benefits offered by the veterans' facilities.

(A) To relieve the burden on veterans' facilities by having cases that can be treated at the patient's home or doctor's office so treated.

(B) To prevent loss of time and save difficulty of travel for the veteran, and not send him to the veterans' facility unless same is necessary.

(C) To use local hospital facilities for acute and subacute cases.

(D) To save the bed capacity of veterans' hospitals for chronic cases or those that cannot be treated locally.

(E) To put at the disposal of the veteran and the Veterans Administration all local reputable physicians, including the specialists. Many of the busy and better general practitioners, as well as specialists, would not sign up under the usual procedure because they are busy enough anyhow, and do not have time, or in many cases the clerical assistance to fill out government forms, et cetera.

(F) To provide a local experiment in cooperation between government agencies and organized medicine. Such experimentation is better on a local basis than a national one. The number and distribution of physicians and hospitals in the county, together with local cooperation and good spirit prevalent between the medical profession, the hospitals, and welfare agencies, is, in our opinion, ideal for experimenting in this country.

Plan:

(1) All physicians, members of the St. Joseph County Medical Society, and those who are not members but are approved by the county society, shall become ipso facto physicians designated to care for veterans.

(2) The St. Joseph County Medical Society will present an approved list of physicians, to be made available to returning veterans in need of medical care but who are not of an emergency character. The examining physician will have available a list of competent consultants to whom he may call for further professional services needed by the individual patient. The County Medical Society will also provide a reference committee for the purpose of receiving complaints from patients, physicians, and the Veterans Administration, in order to assure the Veterans Administration that the patient is receiving competent and adequate medical care. The compensation for physicians treating patients will be on a fee basis, at a price list to be negotiated and accepted by the Veterans Administration and the County Medical Society.

Emergency Cases:

These cases will be taken care of by local physicians and hospitals until the exact responsibility is determined by the local Veterans Administration, just as any emergency cases arising in the community.

With the tremendous number of veterans there will be after complete demobilization, the present Veterans Administration hospital facilities will have a very large burden. This plan will tend to relieve them of many cases that can be taken care of locally. The veteran, in turn, will receive the same medical care as the rest of local citizenry, as a minimum, and in most cases better because he will have the advantage of the sorting or trial group to see that he receives care from a man well qualified to give it. In addition, he will have the advantage of the veterans' facilities when such are indicated. He will have a choice of personal physicians so far as such choice meets the need in his case, and this will be an opportunity to test whether putting a large measure of responsibility on a local organized medical group will pay dividends and give better service to the veteran, and better cooperation with government agencies, if this is done on an independent basis between the individual physician and the Veterans Administration.

DR. GIORDANO: That is our Plan, as submitted to General Hawley. He replied:

"Because of the great number of counties in the United States, which number around three thousand, it is much more preferable that agreements for the care of eligible veterans be made at a state-medical-society level. Therefore, it is suggested that you contact your state medical society relative to the possibility of representatives of the state medical society coming to Washington, D.C., for a conference, for the purpose of entering into an agreement with the Veterans Administration covering out-patient treatment, physical examinations, and hospitalization of eligible veterans. It is anticipated that a letter will be directed to the state medical society from the Veterans Administration relative to this matter."

I believe the House should consider this matter so that it will not be delayed. In our community a large number of veterans are coming back and the amount of malaria we are seeing is considerable. Many patients have been sent to Chicago, and it is ridiculous for them to have to be sent there.

DR. SPARKS: I notice in your remarks that you differentiate between service-connected disabilities and non-service-connected disabilities. Is the Veterans Administration changing its attitude? In the past they took every patient into the hospital.

DR. GIORDANO: If I understood General Hawley, he very emphatically stated that they were going to limit the care to service-connected disabilities, and only a few non-service-connected disabilities will be taken care of. That was my understanding.

DR. FERRELL: Do you wish to take action upon this report? We will entertain a motion to that effect. Does anybody care to discuss it?

DR. CAYLOR (Wells County): I move that we accept the suggestion made by Dr. Giordano, and if suspension of rules is necessary, let's suspend them and consider the proposition. (Seconded by Dr. Rozelle, of Madison County.)

DR. FERRELL: Is there any discussion? You have heard the motion, as stated. Are you ready for the question? ("Question.") All in favor of the motion as stated, say "Aye"; contrary, "No." (Motion carried.)

We have just had a report that Dr. Kennedy is in the city and on his way here. He has been sick, and it has been difficult for him to get here.

DR. NAFE: Couldn't we take up the problem, relative to what we are going to do about the situation Dr. Giordano has placed before the House, for consideration? The vote was to suspend the rules. It would seem to me that this is one of the most important issues we must face, and we certainly must make some decision. It seems to me that we must very definitely set up an organization in our state to care for the veterans, as requested by General Hawley. We are behind a good many states now in setting up a program to cooperate with the Veterans Bureau. For that reason I make the motion that the president be empowered to appoint a committee to work out a plan as suggested by Dr. Giordano, for cooperating with the Veterans Administration in the care of these cases, and that it be submitted to the Council for its approval in April.

(Motion seconded by Dr. Black.)

DR. SPARKS: Would it go back to the Council, which doesn't meet until April? The men here represent most of the societies. They could take this back to their societies now and get the thing before them. It seems to me that if we are to have uniform action that perhaps a fee schedule should be arranged on a state basis, and all societies should conform to it. But we can get much more rapid action if we take this matter back home now and get action back to the state headquarters from the county societies, rather than go from above down.

DR. NAFE: As part of my motion, it seems to me that each society could not set up a fee schedule. It would be the duty of this committee to suggest a fee schedule, but it also seems to me that we would have to have a Council meeting to approve that program, unless you want to give this committee the power to act without its approval, but that is a lot of responsibility.

DR. FERRELL: As I understood it, if you heard General Hawley at the Secretaries' Conference, my impression was that the fees to be charged are to be in accordance with that of the local society. Am I right or wrong?

DR. NAFE: Yes, but he wants it on a state-wide basis.

DR. FERRELL: He has probably changed his mind. There is a motion before the House. Are we ready for the question?

DR. HAUSS: I would like to move that the motion be amended, to give this committee in joint connection with the Executive Committee, the power to act on this subject, and in that way it would not be delayed until the Council meeting in April. I think that this thing is important, and I believe that the chair can appoint a committee, along with the Executive Committee, which would be capable of handling this thing if they are given the power by the House of Delegates at the present time.

DR. JONES: I think that this plan is very suitable, and that it is time to act, and I will second the motion. (That was Dr. Jones, of Madison County.)

DR. FERRELL: You heard the amendment, as stated. Is there any discussion?

DR. BEGGS: I think that before a committee should act on this matter, it should be presented to our county societies, so as to let them know something about this plan before final action is taken. I do not think that most of the members of the county societies know anything about this plan, and I feel that they should express their desire in this matter.

DR. ROMBERGER: May I ask whether or not the Veterans Administration has submitted a program to the state, on a state level? If not, it would be the committee's function, it would appear to me, along with the Executive Committee, to negotiate with General Hawley, representing the Veterans Administration, to see what they have to offer before we submit it to the House of Delegates, which represents the county societies.

DR. GIORDANO: It says to give power to the committee to go ahead, proceed to negotiate and close the negotiations so as not to lose any more time.

DR. AUSTIN: The Wisconsin State Medical Society has already worked this out, and in the current issue of their Journal the entire problem is outlined, together with the fee schedule that has been accepted, and as provided by the Veterans Administration, so if they will get a copy of the *Wisconsin Medical Journal* they will save themselves a lot of work.

DR. CLARK: I do not know of any way to create more discontent among doctors than to tell them what they can or cannot charge. I do not know any way to create more discontent and ill feeling between the Veterans Administration and our state organization than to have a certain number of doctors making repeated house calls on some asinine thing. I think that this thing should be considered by the individual county societies. It takes longer, that is true, but you are going to have much less kickback from the standpoint of the management, both as to the fee schedules and of the matter of auditing the accounts, which I think will have to be done under any sort of program that would be set by the Veterans Administration.

DR. PAINTER (Randolph County): I know the doctors in our county. In considering the matter that we are to take up later this afternoon, we have brought up this same subject several times, and I know that they are going to be very unhappy if the fee schedule is set up without their consideration. I would agree thoroughly with Dr. Clark's suggestion that this matter be brought to the county societies for action first. I would suggest that this committee, if it could do so promptly, set out an ideal arrangement, using the plan as outlined as a basis, with a suggested fee schedule, and send it out by way of the state society to the county societies for consideration at their first meeting, and try to get as quick action as possible in that manner.

DR. FOX (Daviess-Martin County): Our doctors won't know much about it. I agree with Dr. Clark; you tell them what to charge, and they will not like it; whereas if we bring it before the society and discuss it, they will have some idea what it is all about.

DR. MITCHELL: Did General Hawley make a statement about this, or whether so far they have had any dissatisfaction about it?

DR. CLARK: What are the fees charged in Marion County? They vary from $1.25 to $18.75. That is true everywhere. It is perhaps a matter of the county society accepting a fee lower than they would have to, but if you say "You are going to accept this, which is two dollars more than they ordinarily would get," they are going to "beef." Wait and see.

DR. THOMAS (Tippecanoe County): I am opposed to this body of ninety-eight members going on record as adopting this. I want all of my county members to have something to say about a fee.

DR. MINOR MILLER: It seems to me that they said something at the secretaries' conference we are forgetting. If I understood General Hawley, he said that they made some of these agreements on fees with the state associations along the line and adopted the fee schedules as set forth in the insurance plan that the state used. Since we are trying to set up an insurance plan, it seems to me that this might be the chance to get our fee schedules.

DR. FERRELL: I think that we could discuss this all afternoon and not get an agreement about the whole story. I am at your mercy, of course, but let's get on, if there are no objections. We are voting on the amendment.

DR. CLARK: To clarify this, does that mean that the Committee, without consultation with the county societies, has the right to go ahead and do business?

DR. FERRELL: According to the motion, it means "yes," if they desire to do so. All in favor of the amendment as stated, say "Aye"; contrary "No." (Motion was lost.)

DR. FERRELL: All in favor of the original motion, say "Aye."

(A standing vote was taken, resulting in fifty-one "Ayes"; seventeen "Noes.")

The "Ayes" have it, and the motion is adopted.

DR. CLARK: In order to clarify this for some of the people that voted "No," I think it will be taken by consent that the matter of referring the thing to the Council means that it will automatically go to the county societies for final action.

DR. ROMBERGER: There is nothing more desirable at a time like this than unity, and if we don't have unity, if we don't have the backing of these county medical societies, we are going to have nothing but discord.

DR. RUDDELL: I do not know what the final action will be concerning insurance before this body, but I believe that General Hawley made arrangements with the Michigan State Medical Society to tie this work in with the insurance plan they have there, and that answers a lot of questions, especially the one Dr. Clark made, which I think is very important.

DR. FERRELL: California, Wisconsin, and Kansas have done that, too.

Gentlemen: I will entertain a motion that we go into session to hear the report on the insurance proposition that is going to be before you. (Motion was taken by consent.)

I wish to call upon the president of the Council to make an announcement in regard to this.

DR. MITCHELL: More than a year ago this question of prepayment medical care was brought up at the House of Delegates, and at that time they adopted an indemnity type of insurance to fulfill the needs in the state. It was turned over to a committee to formulate a plan, which they brought up at the last meeting of the House of Delegates, and then it was turned over to the Council for working out a plan. The Council appointed a committee immediately after the last state session, and they had a meeting in December, and one two weeks ago. This committee has been working on a plan —they worked on three different plans— and the Council adopted the mutual indemnity insurance plan for prepayment medical care. The chairman of the committee who worked on these plans, Dr. Kennedy, of New Castle, will give you the plan that the Council feels is the proper plan for operation in the State of Indiana.

DR. KENNEDY: The Council, in compliance with the direction of the last meeting of the House of Delegates, has studied, adopted, and presents for your final approval a definite plan on the indemnity type of the mutual form for an insurance organization for the State of Indiana. It seems that this is the time for decision. All about us the other states have organized and have in action, or are in the process of organizing, these companies of various types, all of which have the same ultimate aim; that is, of meeting an overwhelming public demand for avoidance of the costs of catastrophic illnesses among the people who are less able to take care of it. We have no concern with the well-to-do people. They have always been, and will continue, able to afford such care and pay such rates as may be fair. It is for these people who are above the indigent class, the men of low incomes, who complain that they cannot have the things that we have taught them they ought to have. We are partly to blame for this. We have insisted, day in and day out, that there are certain standards of medical care every man ought to have. We have insisted that if all people could have this we could raise the standards of health in the United States to unprecedented heights, and we have sold our people thoroughly. With their firm belief in our knowledge of the subject, they have taken it literally, much more literally perhaps than we really intended, because we know that medical care itself is not the sole factor; that the question of housing, clothing, food, and amusement enter into the health question as well. But our people do not know that; they are sold on the medical thing, and they demand it. They say, "You have told us that we need this special care," and since health is a personal thing to everyone, they want the best, and yet they find themselves unable to meet the constantly-mounting costs thereof. Few men are unable to pay for the minor things; it is the major things that put them deeply in debt that make it difficult, and they often are restrained from having care that they believe they ought to have; and possibly they are right, but because they are unable to finance it they demand that it be given to them.

The natural place to look for it is from the medical profession, and they say to us, "Give it to us, make it possible to have these things that you say and that we believe are necessary for our general welfare; and if you won't give them to us, there is always a place we can go where we will get these things, and that is the limitless resources of the national treasury." As a result of this a tremendous demand has been built up. You are all aware of it. We are simply fighting now to protect those things that we hold valuable. We know what it means to have compulsory health insurance, but we cannot sell the people on that. They look upon any type of medical service as inherently and naturally of the highest type. They cannot understand what it means when it gets upon a grossly commercial basis of multiple work for relatively small fees—what it means to them. When they find it out it will be too late, because if any of these measures go on the statute books they will never come off. So we are fighting not only for the future good of the people whom we profess to serve, but for the maintenance of these standards that we

ourselves have set up and that we believe in. We are doing it partly for the good of the people and partly for the preservation of our own economic status, and for the maintenance of our own medical standards.

There has been a long delay in coming to a decision. We have talked it over and over. Doctors are inherently individualistic. It is difficult to get them to agree upon things. Insurance is a special profession, and we have naturally (and in that I heartily agree) been reluctant in taking over these things, but there are times when men must drop their personal beliefs and the things they would like to do, in order to protect the things they now have. Some of my friends feel that these things are inevitable. For the last twenty years some of our members have been pointing out this rising tide of demand for governmental control. When I first came to Indiana, Dr. Austin was a lone voice preaching its possibilities; at times some of the rest of us added our voices, became a bore, and quit talking about it. The general attitude was, "it couldn't happen here." But it followed the same plan it did in other countries, an increasing demand which was not met by the profession, and our chance, it seems to me, is this: some form of insurance in which we can meet the demand. If arrangements can be made whereby we can not only meet the demands of the people of the lower grade, but of the higher income class, it is all to our benefit. If we take certain types of insurance —if we have various types—there is no loss. We do not have to meet those. Ours is elastic, to meet any particular kind of demand that may arise, and your committees have constantly sought to make studies of these demands. (Let me assure you there have been intensive studies and investigations. We have gone to the bottom, so far as our capacity permits, and again I want to express a deep appreciation for these men who have served on these committees with me, for their unselfish loyalty to the good of the profession, in giving their time and money that the rest of the profession might not have to do it and yet be well informed.)

This delay we have had has perhaps been of value. We have had time to study, think over, iron out our impressions and prejudices, and possibly come to a realization for our own good and the generations to follow that we need to adopt something which will apparently fill the need. It is not Indiana's view alone that this is the best way of approaching this onslaught upon the profession; it is the opinion of men all over the nation, and the result of that opinion in every state in the union has been the organization of these associations. Illinois has an enabling act which will enable them to have one within the next ninety days. Missouri, Ohio, and Kentucky have already authorized such an organization. We are surrounded by states who have adopted these plans. From the Atlantic to the Pacific practically every state in the Union has in effect or in organization some type of insurance plan. In Indiana we cannot afford to stand back and fail to hold up the leaders of the profession, who feel, after long consideration, that this is our best opportunity for preserving the things that we most desire.

So the time we have spent in study and recapitulation, and in discussion, probably has been fortunate. It is now time for a decision. Whatever it may be, let us make a final decision, and make it today, so that we may go ahead. You are all aware of the fact that all political parties have announced approval of the compulsory health insurance plans. You know that the President of the United States twice in his messages to Congress has taken a strong stand for approval thereof. The time is growing short. This is the day of decision, and whatever you may do, it should be done finally today.

We older men are not particularly concerned about these things. We are going to pass out of the scene before long. What we are doing is largely a labor of love. It is a desire to maintain for those coming after us the things that have been handed down by former generations. It is a matter of principle, of obligation, that we shall not fail to do anything which may be of benefit to those who come after us.

Your committee in all its studies has had certain basic principles, and every plan that has been investigated has been checked against those basic things, to see whether or not these principles applied; primarily, that the Indiana State Medical Association itself, as a corporate body, should not have any financial responsibility for the operation of the company; second, that whatever plan was adopted should be wholly, entirely, and completely under the control of organized medicine; third, that whatever plan was adopted should be actuarily sound— a good business proposition; and fourth, that whatever plan was adopted should be adequately financed. It is folly to start any business organization without provision to carry on in the event of possible losses. Even the corner peanut stand must have some reserve behind it. Finally, we have adopted the principle that it must be a non-profit organization, and by non-profit we mean that no individual, or group of individuals, shall personally profit by the operation of any organization we may adopt.

Your Council, after studying multiple plans and the recommendations of its committee, with the assistance of its attorney, have set up such a plan, and if I may have your closest attention, I think it will answer any possible question in your mind as to the aims thereof, the objects, and the methods of operation. I will read it to you—the proposed Articles of Incorporation. If you have a copy and will follow me, then when I make the motion following this, if there are any questions or anything that is not clear that I can answer, I shall be happy to do so. I do not intend to enter into any argument, but if there are factual questions I can answer, I will be happy to help you in clearing up any misunderstandings.

The following plan was read by Dr. Kennedy:

"MUTUAL COMPANY

"ARTICLES OF INCORPORATION
OF
MUTUAL MEDICAL INSURANCE, INC.

"The undersigned, being seven or more natural persons of lawful age and citizens of the United States, at least a majority of whom are residents of the State of Indiana, do hereby adopt the following Articles of Incorporation.

"Be it remembered that the following Articles of Incorporation and all matters heretofore done or hereafter to be done are in accordance with "An Act concerning insurance, and declaring an emergency," approved March 8, 1935, and all acts amendatory thereof and supplemental thereto.

"1. The name of this corporation shall be,

MUTUAL MEDICAL INSURANCE, INC.

"2. The post office address of its principal office shall be ————————————, Indianapolis, Indiana.

"3. The purpose or purposes for which it is formed are as follows: To insure against medical and surgical expense to the extent fixed in Certificates of Membership, the said insurance being in Class 2-(1), under Section 59 of the Indiana Insurance Law of 1935; and to do all the things necessary and appropriate for carrying on the business of such an insurance corporation, and to exercise all the general rights, privileges, and powers authorized by the Indiana Insurance Law of 1935.

"4. The plan or principle on which the business is to be conducted is: Representatives of the medical profession of the State of Indiana, recognized and accepted among the profession as members in good standing and repute, will develop and conduct an indemnity plan of insurance against the costs of medical and surgical care, with the intention and purpose of rendering a public service by providing such methods and plans as study, experience, and needs may require, whereby adequate medical and surgical care for all may be more satisfactorily provided for. To accomplish that end, this corporation shall operate under the Insurance Laws of the State of Indiana as an insurance company, and be the instrumentality through which prepayment for medical and surgical care may be arranged for those who become members of this corporation, all of which shall be done without the purpose of making any profit out of the management, control, and operation of this corporation.

"To make certain that this corporation shall always operate in accordance with the plan or principle herein stated, a majority of the Board of Directors shall always be members of the medical profession holding unlimited licenses to practice medicine in the State of Indiana, and of good standing and repute in the medical profession; and the remaining members of the Board of Directors shall be such as in the judgment of the Board of Directors will afford reasonable representation on the Board of various groups and interests in the state concerned with the provision of adequate medical care for all the people of Indiana.

"Policies in the form of Membership Certificates, approved by the Insurance Department of Indiana, shall be issued to those who obtain insurance in this corporation,

"5. The term for which it shall continue as a corporation shall be perpetual.

"6. There shall be no capital stock.

"7. The amount of paid-in capital in the form of contributions with which the company will begin business will be $65,000.00, of which $25,000.00 in Government Bonds is to be deposited with the Department of Insurance, and $40,000.00 is to be available for organizing and operating expenses. In addition to the paid-in capital in the form of contributions there will be $25,000.00 to be paid in as advance premiums before beginning business. For the contributions the corporation will issue Certificates of Advancement bearing interest at four per cent per annum, which certificates both as to principal and interest shall be payable only out of the surplus or earnings of the corporation.

"8. The names, occupation, and post office address of each of the incorporators are as follows:

NAME	OCCUPATION	ADDRESS

"9. The names and post office addresses of the first officers, directors, trustees, and their term of office, or other persons who have and exercise the general control and management of the affairs and funds of the corporation are as follows:"

Interpolation:

We had hoped that we might use the word "Indiana," but we are forbidden by law. I had a long talk with the Department of Insurance this last week, and that was a very satisfactory one. We shall be sure of hearty cooperation from the Department of Insurance in whatever we may do. That cooperation is of tremendous value, because all organizations have their troubles in the beginning. If they have losses, the State Department can be hard and require additional funds, or the State Department can look over some of those things and take cognizance of the possibilities of loss and possibilities of recouping them, and let us go along, so the closer we work with the State Insurance Department, the better off we will be in every way; and I am happy to say that we have their very earnest cooperation and their best wishes, particularly on the plan we presented to them, and I may say, unofficially, that they will be approved and accepted by the State Insurance Department.

The By-Laws, which are not a part of the Articles of Incorporation, but are to be adopted by the proposed Board of Directors, should include the following provisions:

"SUGGESTIONS REGARDING BY-LAWS

"The By-Laws should include the following provisions:

(a) The time and place of holding, and the

manner of conducting meetings of the members of policyholders, and of directors;

(b) The manner of calling special meetings of members or policyholders and directors;

(c) The powers, duties, tenure, and qualifications of the officers of the corporation, and the time, place, and manner of electing them;

(d) The creation and appointment of executive or other committees and the number of members thereof, and prescribing their powers;

(e) The classification of its risks and of its members, and the creation of a surplus fund or funds; and

(f) The manner of creating and exercising proxies.

"The By-Laws generally include, in connection with the item above-mentioned, a condensation of the law which governs with respect to each of these items; and where this is done the By-Laws constitute a guide for the conduct of the corporation covering what is required by law as well as what may be within the discretion of the corporation itself. A complete set of By-Laws covering fully all these matters should be adopted by the Board of Directors of corporation. But it would include more detail than is deemed necessary for this meeting.

"This meeting should decide on the selection of incorporators and the first Board of Directors."

The plan proposed, in the judgment of your committee, and which has met with the approval of your Council, covers all the needs of insurance. It is sufficiently elastic in its form to permit changes as may be required by study, or by the requirements of experience. However, fast, fixed, and bound firmly, the basic thing is that the control of it shall always be in the hands of organized medicine, and while the Indiana State Medical Association does not legally become responsible in any manner, shape or form, yet the method of proposing and of nominating directors for it is fixed by adopting the motion which I shall later read, by the president and the Council, and that again is always subordinate to special action by the House of Delegates. It has been fixed, definitely and firmly, in the organic construction of this plan, that it shall always be under the control of organized medicine. The possibilities of financing this thing are through subscriptions from physicians in the form of loans. There is, however, no limitation as to where these subscriptions may be secured. It would, however, be possible, to support this, to ask subscriptions from drug interests, or from philanthropists, or other people who might be interested in this particular thing. It is my understanding that the Blue Cross was largely financed in this way, but our basic source of income will be through solicitation of the profession for loans to the proposed company.

It is possible, under the plan, not to have to set up a complete organization of our own personnel, to get highly trained men, which are difficult to find, and incur a lot of time and delay. The biggest thing is the selling and the collection of the fee of the certificates. A tentative proposal has been made to us by the directors of Blue Cross, not on formal contract, but a tentative offer which I think will be agreeable, that they will take over the selling of the contracts and the collection of the necessary fees, on a basis of a mutual division of the net costs, because it is the intention that these policies of insurance be sold only to those who also hold Blue Cross certificates. We feel that it is for the mutual good, both of Blue Cross and ourselves, that we join them, so that one fee is all that a contributor has to pay. He will get a complete service, based on the one policy, but the settlement of the fee scales, the payment of the indemnities that may occur, will always be done by our own organization. We will always have in our own hands the settlement of how much that indemnity shall be, to whom it shall be paid, and under what circumstances it shall be paid. There will be no need for any contracts. No doctor will have to enter into contract with the company. The contributor, policyholder, buys his contract, and he deals solely with this organization. This money, if he has a claim, is paid, and there will be a provision by which that money is not paid to the contributor but to the one who renders the service, so that the money will come to him, and there will not be any question of it being frittered away. That can happen, because I have had two such instances within the past week, so it is rather a sour subject with me. I feel that this is one thing we want to bind firmly into anything we may do, that the interest of the profession shall be constantly provided for, and by maintaining control entirely within a group that comes out of our own Council, our own society, we know that we have that control against any form of onslaught that might be made against us.

The Council has directed that this plan be recommended to you for adoption. In order to effectuate it, I propose the following resolution:

"BE IT RESOLVED, That the Indiana State Medical Association cooperate with a group of incorporators as herein provided for in the organization and carrying on of a mutual indemnity insurance company for the purpose of insuring against the expense of medical care, including both surgery and medicine, to the extent and under the limitations which may be fixed by the Board of Directors of such mutual company; but with the definite understanding that no financial liability is incurred by this Association as such, the intent and purpose of this resolution being only to be a statement of support and intention of cooperating in making the said company successful as the instrumentality through which the medical profession in Indiana will attempt to provide medical and surgical care for those of low income through a prepayment or insurance plan to cover the cost thereof, or so much of the cost thereof as may be stated in the policies issued by the said company; and,

"BE IT FURTHER RESOLVED, That the President of the Indiana State Medical Association be and hereby is authorized and directed to appoint, with the approval of the State Council of this Association, not less than seven members of this Association, who are willing to serve, as incorporators and as the first members of the Board of Directors of said corporation; and that said incorporators when appointed be requested to proceed with the organization of such a company upon the assurance that the Indiana State Medical Association, through its separate members, will encourage and support the organization, the development, and, when organized, the efforts at successful operation, of the said company; and,

"BE IT FURTHER RESOLVED, That this approval and statement of willingness to cooperate, in the manner hereinbefore set forth, with said corporation, is upon the condition that the said incorporators incorporate the said company in such a manner as to keep the power of control and management thereof in the hands of those who are approved by this Association as representatives of organized medicine in the State of Indiana, so selected as to demonstrate the purpose and design of widely democratic representation of the entire profession."

DR. KENNEDY: By direction of the Council, I move the adoption of the resolution. (Seconded by Dr. Clark.)

DR. FERRELL: You have heard the resolution. Dr. Clark seconded it. It there any discussion?

DR. NIE: I read this pamphlet. I made up my mind that I would be for it, and I think I still am, but I would like to have this explanation made. If this insurance company is organized and operated a year or two and then fails, I do not want to be duty-bound to cooperate any further. They may not get any of my dollars, but if this thing flunks—it might, lots of insurance companies do—I do not want to be under obligation to cooperate any further. I think that we ought to have that understanding. There are only about sixty-eight successful life insurance companies, and I am in favor of cooperating as long as it is all right, but when you go on the rocks, I do not want to cooperate.

DR. DANIELS: I do not want any of the money that we have in our sack to be responsible, either. I am not in any danger. I haven't got anything.

DR. SCAMAHORN: I wonder, if the Blue Cross takes over, will it be an individual, family affair, or sold in groups like the Blue Cross? I have seen two letters from men who were on strikes, saying that the Blue Cross was not effective because they were on strike. Seventy-five per cent were not working, and their insurance was no good until they went back to work, although it was paid up. I would like to know if it is a personal thing, family thing, or group affair.

DR. FERRELL: Dr. Kennedy, will you explain these points?

DR. KENNEDY: I can conceive of no time in which the Blue Cross would not be responsible for the carrying out of any contract for which it had been paid. I am informed by one of the directors that they had a temporary slump, caused by some early shut-downs, but in spite of that they have increased their reserves in the last month. They are perfectly solvent, and any man who has a paid-up contract with Blue Cross in the State of Indiana can have the service set forth in his policy. (Mr. Stump said that was right.) Does that answer your question? If a man had a policy in any company not being paid for, he would not be entitled to future benefit. It is a matter of business; he pays for something—he gets something; when he does not pay, he is not entitled to it. There ought to be, I think, some humanity used in these things. I think that there ought to be plans by which people could possibly make loans or security, so they would not need to drop it in times of depression. Some organization has announced that they will pay Blue Cross dues and take the premium from their wages when they return. Someone must pay for those policies, because otherwise there would not be any money in the treasury.

There was an implication that I think we ought to make clear. This proposed company is a medical company, and is supreme in its own function. It is not in any way a subordinate to any other organization. It will work with the Blue Cross, as a companion organization, but the growth or fall of the Blue Cross does not necessarily have anything to do with the progress of the medical company; and under the provision here, if it were determined desirable, we could incorporate the Blue Cross and take them with us, and I think at some time that might be, if it should be deemed desirable, but under our proposed charter we are not limited to doing any one thing—we are supreme in what we are doing, and no one except our own directors, the Council, and this body, can tell us what or what not to do. There is no obligation to a defunct company. If it should go broke we would all be out of it.

DR. VAN BOKKELEN: The question has been raised regarding joining on a group or individual basis. The Blue Cross is sold on a group plan, and I do not see where you can get a rural population to join groups, or why it should be expected to do so.

DR. GIORDANO: There are many communities that would not care to have the Blue Cross hospital plan, because many communities do not have sufficient beds to go around, and there is no reason for the medical plan to fail because of it. We should see to it that communities who wish to buy the medical plan alone may do so without any strings attached to the Blue Cross plan.

DR. CLARK: I think that any reference to the Blue Cross is simply a matter of it being the starting method of selling. It is not the idea of this plan to stay strictly as a group plan, and I certainly would object to any plan which made us subservient, or even curtailed our activities, by association with the Blue Cross or any selling outfit.

I think that eventually it is going to be up to each local community to have someone sell this particular plan, rather than to rely on a central selling agency. I do not believe that Dr. Kennedy has any idea of making this subservient to the Blue Cross or liable to it for anything.

DR. KENNEDY: I certainly could not have been misunderstood. That is an independent company, supreme in its own right, not subservient, not attached to anybody, and any contracts it might make are contracts for the good of this company, and also revokable in some way. We are not detail men, we will run it ourselves and develop it, but to attempt to go into an unexplored field, which no other organization is yet doing, would be financial suicide. This is just common business sense, as you learn to walk before you start to run. Michigan had the experience of going wide open. They lost a half million dollars. Now they are commencing to feel their way along, to see how far they can extend these things with safety. The question of safety in the organization always must be paramount with the Board of Directors, and they may experiment as they have reserve which might be used in that way without impairing their capital or impairing the soundness of the policies which they have issued. This company would merely employ the Blue Cross because it already has a working organization. It has salesmen and bookkeeping equipment. It has everything set up, and one of the things that we look on for immediate growth is putting the two policies together. I do not mean one policy. They would get two policies, one in our company, one in the Blue Cross, but we would use one group of people to sell it. Why send two people out, one to sell Blue Cross, one Medical? We possibly would have some people in the field to take care of special conditions. It is possible to maintain these low rates, and this question of low rates to the policyholder becomes of extreme importance. It is only possible by using the group system. If there are individuals who desire it, there must be an additional cost added to that to take care of the overhead expense of handling the individual. Yet it is quite possible to sell this to anybody, but we would prefer from the standpoint of good business to put it in groups. The Missouri plan has worked out beautifully, and they are handling rural communities. They have organized whole groups and then appointed a local bank as the group agent. Then people came in there and paid their contributions at the bank. Those are matters for administration, and whoever we have as our Board of Directors will be of sufficient intelligence that they will put the welfare of the organization first, and then will increase its scope as rapidly as experience and funds permit. There ought to be no limitation. I should dislike to think that the organization must continuously stay within a limited plan. If it is to be of value it has to take in practically everybody, but we do not know the answers to a lot of things, and we have to find them out by going slowly, going within our limits, and then as we have enough finances to permit, do experimental work here and there. Michigan took one county and tried medical care for them, and then extended it to others, until they had a basis of experience, but no insurance company in the United States, even the Federal Government, does not have an experience table by which they can set up a rate; and if the Wagner Act should pass, it would be an unlimited draft on the public treasury for whatever money was needed, without ever stipulating the exact amount, because no one knows exactly what it will cost until it has been worked out by experience, and that would be the impelling force behind the action of any Board of Directors you might select.

MR. STUMP: My remarks will be brief, but I am glad that Dr. Nie asked the question, "If it doesn't succeed what would be your commitment?" You can not cooperate with an insurance company that is not in existence, and once the thing is not found to operate successfully it will be taken over by the Insurance Department and liquidated, and you could not cooperate with zero. There is nothing left.

DR. NIE: If they weren't successful, could they call on the individuals?

MR. STUMP: No, there would be no obligation on any individual member of the Indiana State Medical Association further than what he himself might make in his contribution. If he put in so much, on which 4 per cent interest would be paid, if, as, and when, there were surpluses with which to pay, he might lose that.

DR. FERRELL: You have heard the resolution. Are you ready for the vote? All in favor, please rise.

(Carried by a unanimous, standing vote; none opposed.)

Unanimous. Gentlemen, I thank you! In order to get this working as soon as possible, the matter of appointing a Board of Directors has to come before the Council, and I am asking the Council members to remain immediately after this meeting, in order to decide about your Board of Directors.

Another thing, the press is here; we have a publicity proposition, and they are out here waiting to hear what your decision has been, and I have appointed a committee, by your consent, consisting of Dr. W. U. Kennedy, the President, President-elect, Chairman of the Council, Chairman of the Executive Committee, Dr. Ruddell, ex-officio, Mr. Stump, Mr. Hendricks, and Mr. Smith. If that is agreeable with you, we will meet with the press and put it over.

DR. CLARK: I would like to move that this body go on record thanking Dr. Kennedy for the work he has done.

DR. DANIELS: As tough as I am, I second that motion.

(Applause.)

DR. FERRELL: Here is another matter, our old friend, W. R. Davidson, of Evansville, sends his proxy in favor of the plan as received and the

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Articles of Incorporation. He wanted to be recorded as favoring the plan. We take that into consideration.

All in favor of the motion, as stated, make it known by saying, "Aye." Contrary, "No." (Motion carried.)

(Motion made, seconded, and carried, for adjournment—at 2:50 P.M.)

EXECUTIVE COMMITTEE

December 16, 1945.

Roll call showed the following present: Cleon A. Nafe, M.D., chairman; Carl H. McCaskey, M.D.; N. K. Forster, M.D.; Jesse E. Ferrell, M.D.; Floyd T. Romberger, M.D.; A. M. Mitchell, M.D.; E M. Shanklin, M.D.; Albert Stump, attorney; Thomas A. Hendricks, executive secretary; and Ray E. Smith, assistant executive secretary.

Statements of receipts and expenditures for November for the association committees and THE JOURNAL were approved.

Membership Report

Number of members Dec. 15, 1945	3,386*
Number of members Dec. 15, 1944	3,391
Loss over last year	5
Number of members Dec. 31, 1944	3,400

** Includes 1,628 in military service and 142 honorary members.*

Prepayment Medical Plans

Advisory Committee of Committee on Medical Service and Public Relations of the American Medical Association is to meet on January 11, 1946, with the A.M.A. Board of Trustees, to discuss a national plan.

Organization Matters

The question of membership of physicians in the regular Army was postponed until the next meeting.

Treasurer's Office

The annual audit of books is being made by George S. Olive & Co.

1945 Annual Session, French Lick, Tuesday, Wednesday, and Thursday, November 6, 7, and 8, 1945

Duties placed on Executive Committee by the House of Delegates and Council:

(a) Ten thousand dollars appropriated from surplus to be used at discretion of Executive Committee. Dr. Forster explained that this was done so money would be available for any unforeseen emergency.

(b) Recommendations of Committee for the Study of Lay Activity in Medical Practice. Dr. Forster announced that he had appointed the committee and that names were being sent to state headquarters.

1. Conference of state president with presidents of State Bar and State Dental Associations is up to the incoming president, Dr. Ferrell—No. 1, page 67, House of Delegates Handbook.

2. Appointment of a Constitution Committee is up to the incoming president, Dr. Ferrell—No. 2, page 67, House of Delegates Handbook.

3. Administrative chart is to be prepared by the executive secretary and published in THE JOURNAL—No. 3, House of Delegates Handbook.

4. Reading of minutes of Executive Committee meetings, as printed in THE JOURNAL, at meetings of county societies is the duty of secretaries of the respective county societies—No. 4, House of Delegates Handbook, page 68. No change.

5. Attorney to prepare an article for THE JOURNAL, setting out that physicians have no legal right to deprive an indigent patient of his right of privileged communication by disclosing any facts about him to lay persons. Article to be approved by Executive Committee before publication—No. 5, House of Delegates Handbook, page 68.

6. Attorney to make a report to the Council that lay organizations which collect money for medical purposes be urged to seek professional advice and make public accounting of expenditures of funds collected—No. 7, House of Delegates Handbook, page 68.

7. Dr. Forster reported that he had already appointed members of a Section on General Practice —No. 8, House of Delegates Handbook, page 69.

8. Committee on Medical Education and Hospitals is responsible for supporting movement for more postgraduate training in hospitals of one hundred beds or more—No. 9, House of Delegates Handbook, page 69.

(c) Cooperation with State Department of Public Welfare referred to Medical Relief Committee—Pages 114 and 115, House of Delegates Handbook.

Letter received from Dr. Romberger was read, expressing his appreciation to the association for being elected president-elect.

Dr. Forster presented copies of "thank you" letters sent to the French Lick Springs Hotel and the convention committees, together with replies.

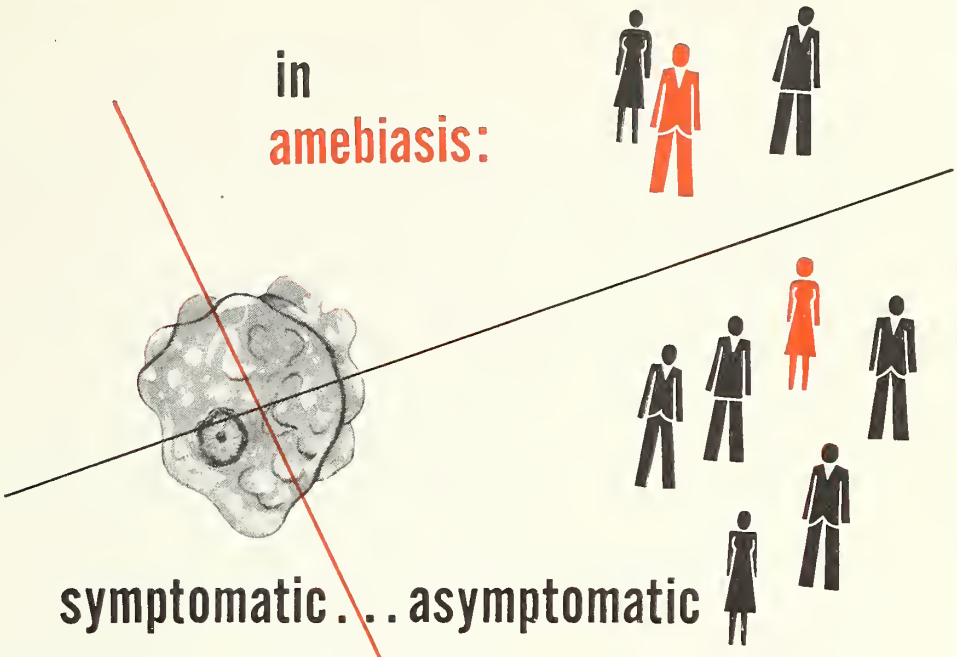
Report of Dr. A. P. Hauss, of New Albany, co-chairman of the Committee on Convention Arrangements, in which he returned $69.56 of funds allotted, was accepted on motion of Dr. McCaskey, seconded by Dr. Forster.

1946 Annual Session

Date for Fort Wayne meeting set for October 1, 2, and 3, 1946, on motion of Dr. Forster, seconded by Dr. McCaskey.

Letter from Dr. Sparks reporting high rental charge for Shrine Auditorium was read. Lack of exhibit space and hotel rooms was pointed out by the executive secretary. Dr. Sparks asked to check conditions and report to the Council at its next meeting.

in amebiasis:



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Barr[1] states: ". . . it is just as important to treat properly the symptomless 'carrier' of this parasite as to treat the patient suffering from amebic dysentery."

Stitt, Clough and Clough[2] report, "The disease may be symptomless . . . These mild or symptomless cases have been shown to outnumber greatly the cases with clinical dysentery. They constitute the carriers or 'cyst-passers'."

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1. *Barr, D. P.: Modern Medical Theropy in General Practice, 2:1830, Baltimore, Williams & Wilkins Company, 1940.*
2. *Stitt, E. R.; Clough, P. W., and Clough, M. C.: Practical Bacteriology, Haematology and Animal Parasitology, ed. 9, Philadelphia, P. Blakiston's Son & Co., 1938, pp. 410-412.*

SEARLE *Research in the Service of Medicine*

The headquarters office was instructed to notify exhibitors of tentative dates and place for 1946 session.

War and Postwar Medicine

Dr. Mitchell, chairman of the Council, announced that the resolution of Indiana veterans, prepared at recent state session, had been presented to the Board of Trustees of American Medical Association, as instructed.

Need for a State Bureau of Information, to work with the American Medical Association Bureau of Information when the Procurement and Assignment Office closes, was acknowledged. Action was deferred after the executive secretary expressed belief that the Procurement and Assignment Office would not close before July 1.

The resolution presented by M. C. Topping, M.D., of Terre Haute, (page 25, House of Delegates' minutes) is to be copied by the state headquarters and sent to Governor Gates and to the State Industrial Board.

Medical Economics

It was suggested that Mr. Samuel E. Boys, Editor of the *Plymouth Daily Pilot*, Plymouth, Indiana, be written that local medical societies were capable of passing on qualifications of orthopedic surgeons and that there is no reason to believe that crippled children would not receive adequate medical care. Dr. Nafe is to approve this letter before it is mailed by the executive secretary.

The Journal

New contract for printing of THE JOURNAL submitted by C. E. Pauley and Company, Inc., was discussed by Dr. Shanklin. The cost of printing THE JOURNAL in 1946 will be approximately 60 per cent higher. The contract was referred to the Council for approval.

Nurse Association Program

Letter from Miss Helen Teal, executive secretary of the Indiana State Nurses' Association, was read. It was pronounced a big program that entailed some study, but the executive secretary was instructed to write Miss Teal that the committee would cooperate in principle.

Statement by Dr. Forster

The meeting concluded with Dr. Forster, retiring president, expressing heartfelt thanks to the committee for the excellent cooperation given him throughout the year. Dr. Nafe, in reply, paid tribute to Dr. Forster, and the fine president he had been, pointing out how energetically and faithfully he had served Indiana medicine.

There being no further business the meeting was adjourned.

BUREAU OF PUBLICITY

February 5, 1946.

The meeting of the Bureau of Publicity was called to order at 4:30 P.M.

Present: H. G. Hamer, M.D., chairman; Thomas A. Hendricks, executive secretary; Ray E. Smith, assistant executive secretary and secretary of the bureau, and Mrs. Lotys Benning Stewart, publicity and script writer.

The minutes of the meeting of September 24, 1945, were approved and signed.

The following news releases for the "Hints on Health" column going to weekly newspapers were approved:

Week of February 11, 1946—"Take No Chances with Diphtheria."

Week of February 18, 1946—"Soap, the Germ Killer!"

Week of February 25, 1946—"Working with a Temperature."

Week of March 4, 1946—"'Flu' Requires Doctor's Care."

The secretary of the bureau reported that speakers had been supplied for the following meetings:

October 17, 1945—Lions Club, Mentone, with the medical societies of Fulton, Kosciusko, and Marshall counties.

October 25, 1945—Dearborn-Ohio County Medical Society, Aurora.

November 16, 1945—Cass County Medical Society, Logansport.

November 19, 1945—Randolph County Medical Society, Winchester.

December 5, 1945—Wabash County Medical Society, Wabash.

January 9, 1946—Parent-Teacher Association, School 69, Indianapolis.

January 16, 1946—Parent-Teacher Association, School 39, Indianapolis.

January 18, 1946—Cass County Medical Society, Logansport.

Requests for speakers:

February 11, 1946—Rotary Club, Connersville. Attorney of the association obtained to speak on compulsory health insurance.

April 4, 1946—Woman's Auxiliary to the Porter County Medical Society, Valparaiso.

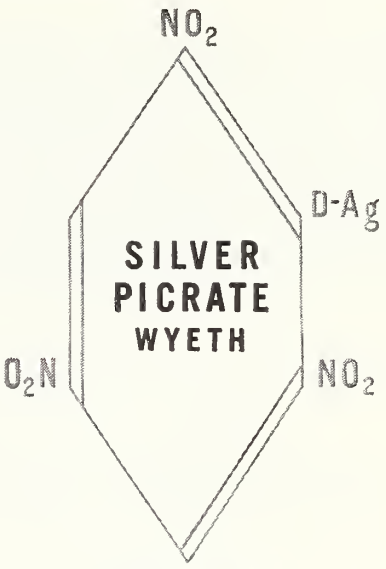
May 8, 1946—Parent-Teacher Association, School 13, Indianapolis. Request referred to the Public Relations Committee of the Indianapolis Medical Society.

The publicity and script writer was instructed to submit all news releases to members of the bureau before releasing them for publication. She reported that radio station WFBM was willing to continue to give time for weekly radio program without charge, but the proposed night program had not materialized because sufficient sponsors were not procured.

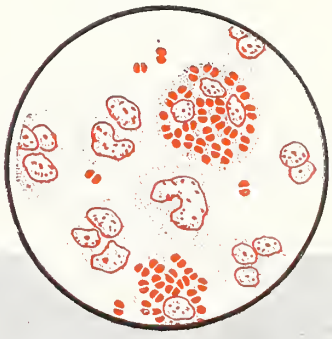
The bureau granted the state library permission to let patrons use medical records on file in the

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library, if the records are not taken off the premises. Permission of the bureau is necessary before they may be taken out of the library. The bureau secretary was instructed to inform the state librarian of its decision.

The bureau secretary reported that the Floyd County Medical Society was running a series of advertisements in *The New Albany Tribune*, pointing out the evils of socialized medicine.

There being no further business, the bureau adjourned to meet again at 4:00 P.M., Monday, February 18, 1946.

The above minutes were approved in each separate part and as a whole on February 18, 1946.

LOCAL SOCIETY REPORTS

100 PER CENT IN PAYMENT OF 1946 DUES

Benton County
Clinton County
Fulton County
Jackson County
Posey County
Scott County
Wabash County

COUNTY MEDICAL SOCIETY OFFICERS

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Vice-President, Milton W. Erdel, Frankfort.
Secretary-Treasurer, T. A. Dykhuizen, Frankfort.

CRAWFORD COUNTY MEDICAL SOCIETY
President, N. E. Gobbel, English.
Secretary-Treasurer, H. H. Deen, Leavenworth.

DECATUR COUNTY MEDICAL SOCIETY
President, I. M. Sanders, Greensburg.
Vice-President, Dale D. Dickson, Greensburg.
Secretary-Treasurer, H. S. McKee, Greensburg.

HARRISON COUNTY MEDICAL SOCIETY
President, Edgar W. Murphy, Lanesville.
Vice-President, Guy D. Baker, Crandall.
Secretary-Treasurer, William E. Amy, Corydon.

PARKE-VERMILLION COUNTY MEDICAL SOCIETY
President, I. D. White, Clinton.
Secretary-Treasurer, R. S. Bloomer, Rockville.

PUTNAM COUNTY MEDICAL SOCIETY
President, G. D. Rhea, Greencastle.
Vice-President, Secretary-Treasurer, Dick J. Steele, Greencastle.

RUSH COUNTY MEDICAL SOCIETY
President, C. W. Worth, Milroy.
Vice-President, C. C. Atkins, Rushville.
Secretary-Treasurer, R. B. Johnson, Rushville.

SPENCER COUNTY MEDICAL SOCIETY
President, C. L. Springstun, Chrisney.
Vice-President, C. D. Ehrman, Rockport.
Secretary-Treasurer, J. H. Barrow, Dale.

VIGO COUNTY MEDICAL SOCIETY
President, W. E. Stewart, Terre Haute.
Vice-President, S. R. Combs, Terre Haute.
Secretary-Treasurer, A. M. Mitchell, Terre Haute.

WELLS COUNTY MEDICAL SOCIETY
President, Harold D. Caylor, Bluffton.
Vice-President, T. E. Caylor, Bluffton.
Secretary-Treasurer, H. Brooks Smith, Bluffton.

Cass County Medical Society members met at the Cass County Hospital, at Logansport, on January eighteenth. The guest speaker was Dr. John R. Brayton, of Indianapolis, who presented a paper on "Dermatitis and Epidermitis." Twenty members were present.

Clinton County Medical Society members held a meeting at the Clinton County Hospital, in Frankfort, on February fifth. Drs. F. A. Beardsley and T. A. Dykhuizen, both of Frankfort, reported on the special meeting of the House of Delegates held on January twenty-seventh, and the Secretaries' Conference held on January thirteenth, at Indianapolis. Eleven members were present.

Daviess-Martin County Medical Society members met in Washington, on January twenty-second. The ten members present discussed current business.

Elkhart County Medical Society members heard a discussion of the physician's preparation for court cases and his testimony, by Mr. Albert Stump, attorney for the Indiana State Medical Association, at the meeting on January third, at Hotel Elkhart. Thirty-seven members attended the meeting.

Floyd County Medical Society members held a meeting at the Frances Cafeteria, in New Albany, on January eleventh. The speaker for this meeting was Dudley Jewell, Secretary of the New Albany Chamber of Commerce, who requested cooperation of the Floyd County Medical Society in public welfare projects contemplated by the Chamber of Commerce. Twenty-one members attended this meeting.

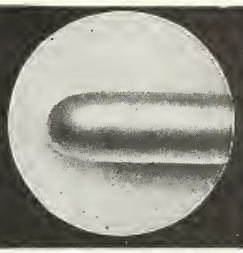
Indianapolis (Marion County) Medical Society members met at the White Cross Service Center, at the Methodist Hospital, in Indianapolis, on February fifth. A case report was presented by Dr. Harry L. Foreman, of Indianapolis. "Round the Red Lamp," by Dr. Oliver, was read by Dr. William N. Wishard, Jr., of Indianapolis.

On February twelfth, at another meeting, a paper on "Small Bowel Lesion with Vague Symptomatology" was presented by Dr. Karl M. Koons, of Indianapolis, and a paper on "General Survey of Peptic Ulcer" was read by Dr. Rollin H. Moser, of Indianapolis.

At a meeting on February nineteenth, Dr. Matthew Winters, of Indianapolis, presented a case report. "Obscure Evanescent Attacks of Local Paralysis" was presented by Dr. Harvey W. Sigmond, of Indianapolis, and "Tumors of the Hand" was discussed by Dr. Allan K. Harcourt, of Indianapolis.

At the February twenty-sixth meeting, case reports were presented by Drs. Harry R. Kerr and Ray Tharpe, of Indianapolis, and a paper on "Surgery of Gallbladder" was presented by Dr. T. B. Noble, Jr., of Indianapolis.

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Henry County Medical Society members held a special homecoming dinner at the Henry County Hospital for returning physicians, who described their war experiences for the thirty physicians present. A discussion was also held of current medical matters, by Dr. W. U. Kennedy, of New Castle, district councilor.

Madison County Medical Society members held a dinner meeting at St. John's Hickey Memorial Hospital, at Anderson, on January seventh. The speaker for this meeting was Dr. A. F. York, of Anderson.

Another meeting was held at Anderson on January twenty-first. Dr. Stephen Rothman, of Chicago, gave a talk on "Ringworms." The meeting was attended by almost a hundred physicians, nurses, and teachers.

Parke-Vermillion County Medical Society members held a meeting at Clinton on January twenty-third. Dr. S. R. Combs, of Terre Haute, discussed chest conditions found in Selective Service inductees in the Fifth Service Command. The meeting was attended by sixteen members.

Pike County Medical Society members met on January sixteenth at Petersburg, for the election of officers for 1946.

Porter County Medical Society members met at the Porter Memorial Hospital, in Valparaiso, on January twenty-ninth. The secretary and president reported on the meeting of the House of Delegates, held on January twenty-second, at Indianapolis. Sixteen members were present.

Putnam County Medical Society members met at Greencastle on January tenth. Officers for 1946 were elected by the twelve members present.

Rush County Medical Society members met at the Lollis Hotel, in Rushville, on January seventeenth, for a dinner meeting. Eight members were present. Dr. W. U. Kennedy, of New Castle, spoke on "Medical Insurance."

Tipton County Medical Society members held a meeting at the Doctor's Clinic, in Tipton, on January eighteenth. In addition to a general discussion, election of officers for 1946 was held. Nine members were present.

Vigo County Medical Society members held their annual banquet on January eighth in the Hoosier Room of Hotel Deming, in Terre Haute. Following a business meeting, a program was presented. Thirty members were at the meeting.

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President-elect—Mrs. S. J. Petronella, East Chicago
Corresponding Secretary—Mrs. C. L. Bock, Indianapolis
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis
Secretary—Mrs. Leon L. Blum, Terre Haute

Allen County: The Woman's Auxiliary to the Allen County Medical Society entertained with a dessert card party for its members on February fifth, at the Fairfield Manor, at Fort Wayne.

Clark County: The Woman's Auxiliary to the Clark County Medical Society held a business meeting Friday, January twenty-fifth, at the home of the president, Mrs. C. F. C. Hancock. A luncheon meeting was held at Rauth's Cafeteria on February twenty-second.

Delaware-Blackford County: Wives of physicians and surgeons who have been and are serving with the armed forces were honored at a luncheon on January fifteenth, in the main dining room of the Roberts Hotel, by members of the Woman's Auxiliary to the Delaware-Blackford County Medical Society. The table was decorated with miniature dolls dressed in Marine, Army, Navy, and Coast Guard uniforms. Placed at intervals were the United Nations flags arranged in standards of red, white, and blue.

Lake County: State delegates to the House of Delegates Convention, which is to be held in Indianapolis next April, were appointed by Mrs. M. B. Gevirtz, president, when the board meeting and luncheon were held by the Woman's Auxiliary to the Lake County Medical Society, on February first, at the Woodmar Country Club. A general meeting was held on February fourteenth at the Indiana University Extension Building, in East Chicago.

St. Joseph County: Mrs. K. T. Knode entertained members of the Auxiliary to the St. Joseph County Medical Society in her home for a meeting in the evening of January twenty-third. The program consisted of a review of the book, "Rickshaw Boy," given by Mrs. L. C. Wilson. Mrs. James L. Wilson entertained on February twenty-third.

Vanderburgh County: The Auxiliary to the Vanderburgh County Medical Society met at the Vendome, on January ninth.

Vigo County: The annual guest dinner of the Woman's Auxiliary to the Vigo County Medical Society was held on January eighth, at the Terre Haute House. Mrs. Joseph C. Smith reviewed the book, "The Peacock Sheds His Tail."



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THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 39 APRIL, 1946 NUMBER 4

CARCINOMA OF THE CERVIX

J. WILLIAM HOFMANN, M.D.*

INDIANAPOLIS

With the ever-increasing mortality rate in cancer, the public at large is being bombarded with literature that has been of some avail in the past three to five years. This educational program which is provided through the American Society for the Control of Cancer and carried out through the efforts of the Field Army of this organization has been highly successful. Its slogan is, "Fight cancer with knowledge," and that is as it should be. The public should be, and is, educated as to the many and varied problems that may confront them in such a condition.

The methods of approach to the public in the program instituted by the Field Army bears some similarity to the many programs instituted for years by the American Tuberculosis Association and its affiliates, and also the United States Public Health, and the Army and Navy health programs. The latter programs have produced definite concrete results, and there is no reason why more definite results should not accrue to the efforts of those in the fight for the early diagnosis and control of cancer.

One of the many phases of cancer with which the general practitioner has to contend, and frequently sees first, is cancer of the cervix. This has its greatest prevalence between the ages of thirty-five and fifty-five years of age, becoming less frequent after this period of life, in counterdistinction to cancer of the fundus which in reality is more predominant between forty-five and sixty-five years of age. As to the cause of this there has been no reasonable answer propounded to date, even as there has been no answer to the cause of cancer although much progress has been made in this field, both through government research laboratories and private laboratories. There is a ray of hope in the offing from some of the research material, but nothing definite as yet.

In the meantime, until the true course has been deciphered, there is much that we can do to lower the morbidity and mortality of this dreaded disease. Particularly is this true in cancer of the cervix, which when situated on the portio-vaginalis part of the cervix is readily discernible upon general inspection and palpation. This is quite an advantage in the early diagnosis and treatment of these cases. Due to its insidious onset the fact is all too evident that the present solution for better end results is periodical examination from the time of the childbearing period and thereafter. At least one or two examinations a year should be made. Following a program of this type I feel fairly certain that we can materially reduce the morbidity and mortality of cancer.

The examination of a patient with cancer of the cervix should consist of approximately six steps; the order may vary according to individual likes and dislikes. My usual order of practice is initially that of doing a speculum examination, which often permits removal of tissue. At this time, in a questionable case or where no outstanding signs are present, it may be desirable to visualize the cancer under magnification with a colposcope and perform an iodine test for glycogen. Obviously, there are times when it may be both inexpedient and dangerous to insert an instrument into the vagina before a careful digital examination has been performed. The second procedure is usually a digital examination of the vagina and the cervix. In this procedure, when there is a known and evident carcinoma, one frequently combines it with a rectal

* Chief of staff of the Gynecological Department of the Indianapolis City Hospital, Indianapolis, Indiana.

examination, placing the middle finger into the rectum, and the index finger into the vagina. By this method one can more definitely ascertain whether there is any extension into the broad ligaments or uterosacrals. This method of approach is far more accurate than by direct vaginal examination. It may be of assistance in the final decision as to the procedure to use in further treatment of the case. Third, bimanual (vagino-abdominal) examination, where possible. From this method one can often decide whether any other adnexal conditions exist, whether there is immobility of the uterus, or whether there is any tubo-ovarian involvement. Fourth, rectal examination, which has been partly covered in the second procedure. In instances of rectal symptoms, a proctoscopic examination is also indicated. Fifth, obtaining tissue for microscopic examination—upon which really rests the true diagnosis of the case. Sixth, cystoscopic examination where there is a question in an otherwise operable case as to whether cancer has involved the bladder, and ureteral catheterization where there is reason to suspect ureteral compression. By following such a routine I question whether one will miss many cases of carcinoma of the cervix uteri. Following this procedure will also assist one materially in deciding upon further procedures in the treatment of the case, whether the case is a desirable one from the operative point of view, or whether it should be handled by x-ray or radiation, or electrocoagulation. Each case is an individual equation in itself, and should be handled as such. This is one field in which I sincerely feel that cooperation between the various specialties of the profession is absolutely essential. This has been particularly brought to my attention within the past five to ten years, during which time I have seen at least ten cases of carcinoma of the cervix, complicated by pregnancy; or if one would prefer to say, pregnancy complicated by carcinoma of the cervix. In all instances pregnancy had been allowed to go on to the second or third trimester before any attention was paid to the cervix. Four of these cases were not observed until the postnatal period. Although the number of cases of carcinoma of the cervix seen during the gravid period is comparatively small, I feel that this was an indictment of our methods of teaching. It seems to me that too much emphasis has been placed upon methods that have a close analogy to the days of prohibition, in that temperance would be far more to the point than prohibition of examination during the prenatal period. Personally, I cannot convince myself of any real added danger in the speculum examination of the cervix during the prenatal or natal period. It is my firm belief and conviction that more of the complications of infection, either ante- or post-partum, are the result of an inherent infected cervix rather than the introduction of infection by the present accepted methods of examination. Therefore, I wish to emphasize to those who do obstetrical work that I believe that the speculum examination has its place during the prenatal and natal phase in the direct observation of the cervix for diagnostic or treatment purposes.

Even during the prenatal stage I can see no objection to a proper and adequate removal of a small amount of tissue for microscopic examination. I do not believe that this entails any danger to the patient or to the passenger within the uterus. I question very much whether this or such procedure properly done in proper hands will ever induce an abortion or miscarriage.

It is unfortunate that the large majority of cases we see are in the advanced stages of the disease, and therefore readily diagnosed on inspection and palpation. Pathological examination is performed only for confirmatory purposes. Carcinoma that begins within the cervical canal, or the inverted type, is the more difficult type for early diagnosis. Here we have the difficulty of lack of direct inspection, and with few, if any, early symptoms. Even palpation is inconclusive except in the more experienced hands. Most of these are of the adenocarcinoma type. Fortunately they comprise the smaller number of malignancies of the cervix, varying from two to six per cent. In the early stages the diagnosis is hampered; also from the standpoint of obtaining tissue for microscopic examination. It is in this type of case one most frequently secures relatively negative pathological reports due to the fact that tissue was not obtained from the malignant area. So it should be evident to everyone that a thorough follow-up in all suspicious cases should be continued for a reasonable length of time, and repeated biopsies should be done until one is firmly convinced of the absence of any malignancy in the part under consideration. One is often surprised at the success of diagnosis by using this method. I recall several cases, one in particular, in which I had removed tissue on five separate occasions and eventually obtained a definite diagnosis of malignancy. This was accomplished over a period of about seven weeks, so the patient did not suffer much by the delayed diagnosis. All precautions were, of course, taken after removing the tissue, by electrocoagulation over the area where the tissue was removed.

Another point of importance is that one should remove tissue from several areas of the suspected carcinomatous cervix, and by so doing one avoids the pitfalls of the follow-up biopsies previously mentioned. It has been my custom to take tissue from at least three to five areas; the amount of the individual piece is, as a rule, from two to five millimeters in diameter, which causes comparatively little, if any, mutilation of the cervix.

It is the consensus among the majority of clinicians that the malignant process is not stimulated in any way by the removal of tissue for histological purposes. There are no proved cases on record which give conclusive evidence of the fact that trauma, as a result of removal of tissue, caused a definite stimulation of growth or extension of the cancer of the cervix.

The various classifications that are used, from a clinical and histopathological point of view, are of importance both from the standpoint of prognosis and treatment. Of the two, the clinical method more nearly approaches the practical method, from our present point of view. The histopathological classification is of significance only in a limited sphere, and this holds true particularly in carcinoma of the cervix. In the majority of instances all three cell layers of the cervix are invariably involved, that is, the spinal or superficial layer, the intermediate or transitional zone, and the lower or basal cell area which is composed of short spindle-shaped cells. These three divisions compose the stratum mucosum. When there is a predominance of one or the other type of cells, it has a definite significance in prognosis. This holds true in metastasis of the neighboring glands. This is more prevalent with the so-called "transitional cell type," and least of all in the spinal type. Practically all cases of carcinoma of the cervix show involvement of all three layers, and in a limited way there is a predominance of the one layer as compared with the others. The more superficial the involvement, the simpler the method of treatment, and consequently the higher the incidence of cure. In fact, in the superficial type all that is necessary is electro-surgical removal of the involved area. In some of the complicated early cases with a limited area of involvement of cancer, upon thorough study and examination one will find metastatic involvement in the surrounding glands of the pelvis and lower abdomen. This is more evident in the transitional cell type of epidermoid carcinoma of the cervix uteri.

The clinical classification is of more material help and importance in prognosis and treatment. Among the many classifications that are used is the one recommended by the League of Nations Cancer Commission. Generally speaking, this divides the growth into stages one, two, three, and four. The first stage is limited to the cervix, over an area which is usually not greater than one centimeter in diameter, and the uterus is mobile. In the second stage the lesion is somewhat more extensive, is spread over the major portion of the cervix, and may have spread into one or more fornices, without definite infiltration of the parametrium adjacent to the uterus—the uterus retaining some degree of mobility. In the third stage we have the above findings, with the addition of nodular infiltration of the parametria on one or both sides extending up to the wall of the pelvis, with limited mobility of the uterus. In stage four we find cases of massive infiltration of both parametria extending to the walls of the pelvis, with complete fixation. Most of our cures come from stage one, varying from sixty to ninety per cent. Stage two causes a material drop in the apparently cured cases, varying from thirty to fifty per cent. Stage three brings even a greater drop in apparent cures, varying from fifteen to twenty per cent; and in stage four we have a drop in the percentage of apparent cures to approximately two to five per cent. The importance of these figures is impressive and convincing in that if one wants to cure cancer of the cervix one must realize that early diagnosis and treatment is absolutely essential.

Of the two types of carcinoma of the cervix, that is, the inverting and the everting type, the inverting type offers the greatest difficulty in early diagnosis. In this type, on gross inspection, the cervix usually has a puckered appearance, varying a great deal according to the degree of involvement of the body of the cervix. With this puckering one may or may not observe either a sero or serosanguineous discharge. Upon bimanuel examination there is imparted to the examining finger a characteristic, almost woody, firmness of the cervical tissue. This latter sign is also present in carcinoma in which the portio is involved. Carcinoma of the cervix has a characteristic firmness on palpation, which to the experienced finger is always suggestive of malignancy. With the inverting type, especially where the growth extends into the canal, the ingrowth obliterates the canal and restrains the mucus secreted within the uterine canal from gaining exit through the cervical canal. Most carcinomas sooner or later become infected, and carcinoma of the cervix is no exception to the rule. A close study of carcinoma in this particular area convinces one that infection is present in the early phase of the disease. The organism that predominates is usually the Streptococcus haemolyticus. Second in order is the Streptococcus nonhaemolyticus; and third, the Streptococcus viridans. Although the Streptococcus haemolyticus is the most virulent, this strain of organism varies somewhat in its virulence. With the obstruction of the cervical canal by the carcinomatous tumor mass which is infected at some time or other, the uterine canal becomes infected and we have a pyometra. A significant diagnostic sign, particularly after the menopause, is that the patient complains of having a sudden outflow of a whitish watery or mucoid discharge. This should put one on guard for some possible pathology along the cervical canal. In most instances one will find malignant involvement of the cervix. Where this discharge is retained, it necessarily becomes infected. Then we have symptoms of pain in the pelvic area, temperature with chills, and in most instances evidence of mild vaginal discharge. Before attempting any treatment of carcinoma in these cases, one must clear up the pyometra by adequate drainage of the uterine cavity through the cervical canal. This is preferably done by electrothermal methods, coning out the cervical canal to permit proper drainage. This method of procedure causes a minimum amount of trauma with the maximum end results. After a reasonable length of time one can proceed by more direct attack upon the carcinomatous area.

To clear up the pyometra, it usually takes three to six weeks before all evidence of discharge has subsided. The endometrium in the menopause has

lost a great deal of its resistance and therefore is more susceptible to infection and the development of pyometra.

Many believe that fibroids are more frequent in carcinoma of the cervix, but according to Healy that has not been his impression during his experience of thirty years or more of close observation. He feels that fibroids are more evident with benign lesions of the breast; next in frequency he found that uterine fibroids are coexistent with carcinoma of the body of the uterus; and third, he found that uterine fibroids are frequently coexistent with carcinoma of the cervical canal. In his experience sarcoma of the cervix uteri is exceptionally rare, according to the available statistics of the General Memorial Hospital, in New York. From the variety of statistics available of uterine cancer, carcinoma of the cervix is usually existent in about eighty-seven per cent of the cases, and in about thirteen per cent in the body of the uterus. Sarcoma exists in 0.9 per cent. So we have a prevalence of carcinoma of the cervix, as compared with carcinoma of the body, in a proportion of about six to one. With sarcoma this is just the reverse, being more prevalent in the body rather than the cervix uteri, although in either case sarcoma is extremely rare.

Syphilitic involvement of the cervix may occasionally be mistaken for a malignancy of the cervix. There may be some definite localized induration suggesting malignancy, but microscopical examination will readily rule this out. Syphilis as a systemic infection apparently plays no definite role as a predisposing factor in the causation of cancer of the cervix uteri. However, where there has been a localized syphilitic lesion of the cervix uteri, there is, according to Gellhorn, a definite predisposition for malignant change to occur. In a case of simple endocervicitis there is an absence of appreciable infiltration. The general color is more of a pinkish red, as compared with carcinoma which is a reddish brown color, or even with a tinge of gray in it. An endocervicitis is practically always present with cancer of the cervix. This is to be expected, for virtually all carcinomas, when seen, are secondarily infected. Nabothian follicle cysts, in the opinion of some writers, are never associated with cervical cancer. This coincides somewhat, although not entirely, with our observation at the Indianapolis City Hospital. This is particularly true in stages three and four, although in stage one we have frequently seen associated Nabothian follicle cysts. These findings have necessarily been few and far between in view of the fact that we see relatively few grade one carcinomas of the cervix uteri. I question whether in the past ten years I have had the opportunity of seeing more than twenty or thirty cases of grade one carcinoma of the cervix. The vast majority of these cases were seen within the last three to four years. Either the patients do not present themselves for early examination or we are overlooking these early cases of carcinoma.

Tuberculosis of the cervix rarely exists, but may be somewhat confusing to the clinician, particularly in the early phases, although in the fairly well-advanced stages or with active ulceration the punched-out appearance of ulcers with ragged edges and with a grayish film on the surface helps in ruling out malignancy, but the final decision must rest with the microscopic study of the involved tissue itself.

Having established a definite diagnosis of cervical cancer, the next procedure is to determine the method of treatment. A thorough history of the case is vital in the best interests of the patient as to the type of treatment to be instituted. A thorough routine physical examination should be performed, including routine urinalysis and red and white blood cell examination. After having thoroughly and conscientiously surveyed the patient also as to the type of carcinoma from a histopathological point of view, and the clinical involvement, one can then proceed along lines which seem most suitable to that type of case. In the earliest types this may need only simple excision through electrocautery, supplemented by x-ray and radium therapy. It is usually advisable to supplement the surgical or electrocautery treatment of carcinoma of the cervix with either radium or deep x-ray therapy, or both. This is particularly true in types two, three, and four, for in most of the more-advanced cases there is always a possibility and probability of some extension along the lymphatics leading from the involved malignant area. Extension of the process along the lymphatic stream has been seen at the autopsy table time and again and proved by microscopic study. The influence of the therapeutic rays of radium and x-ray extends beyond the immediate malignant tissue discernible to the naked eye, and therefore adds to the effectiveness in the possible arrest or cure of the malignancy. As yet there is no perfect treatment known that assures one of an absolute cure in all instances of malignancy, either of the cervix or otherwise.

With either acute or chronic infection of the adnexa, before resorting to any active treatment of carcinoma, the infection should and must be brought under control in one way or another. In the acute type it is preferable to delay any active treatment that will of necessity aggravate the malignancy. One should proceed with therapeutic measures at his command, such as the use of the sulfa drugs and penicillin, which have proved of great benefit and have given relatively satisfactory results in many of the acute cases. In chronic infection with an acute exacerbation, or in the dormant forms, the inflammatory process should be eliminated before instituting any active therapy either by radium or x-ray. In such instances a laparotomy may be performed and the infected areas completely removed. This does not mean complete removal of the entire genital organs, but should be limited to the actual involved tissue, which in most instances is either the tube or ovary on one or both sides. Although not generally advocated,

I am still of the opinion that in type one carcinoma of the cervix, with no undesirable complication, complete removal of the uterus is indicated, together with the carcinomatous cervix and upper third of the vagina. Such a procedure is, of course, unusual in view of the rarity of type one carcinoma, but I am still of the opinion that there are indications for radical surgery in this type of case. I do not advocate such extensive surgery in the simple, uncomplicated type one or early type two carcinoma of the cervix. Under no circumstances is there any indication for active removal of the carcinomatous cervix in either type three or four of the cervix uteri, either with or without inflammatory involvement of the tubes or ovaries. This is in accordance with the opinion of the many reports originating in the various cancer clinics over this country and in foreign lands.

It is unfortunate that there are a few individuals who still practice the technique of surgical removal of carcinoma of the cervix uteri in advanced cases of type three and four. All the cases I have seen or heard of have proved fatal, having encountered many and varied complications, such as vesicovaginal fistula, rectovaginal fistula, ureteral fistula, and ureteral obstruction with secondary manifestations of involvement of the kidney proper. This has left a sad trek of symptoms and suffering to the unfortunate patient and has caused adverse criticism of the medical profession. The profession as a whole has suffered because of the unfortunate attitude of a few. We are judged more by our failures than by our successes, among the laymen, but it is within our control to lessen these errors of commission still being instituted in these type three and four cases. One should have the faculty to control his endeavors of procedure along lines of what is manifestly for the greatest good of the patient; admitting the limitations of surgery and adding such other methods as can be used in a supplementary way, particularly radium and deep x-ray therapy. So as not to be misunderstood, let me emphasize that I personally believe that most of the type three and four cases should have the advantage of an exploratory laparotomy irrespective of whether there is any definite tubal or ovarian infection. By exposing the pelvic cavity through an operative procedure, one can more definitely and thoroughly survey the degree of involvement of the carcinomatous extension outside the cervix. This is of vital importance from the standpoint of the amount of radium therapy or deep x-ray therapy one wishes to give.

After having taken all the above conditions into consideration, it has been our technique, after ruling out surgery as a means of therapy, to resort to radium and deep x-ray therapy. For many years we proceeded in giving radium first and following it with x-ray. Then the pendulum swung in the opposite direction for three or four years, and we preceded the radium with deep x-ray therapy. Now we have swung back to the original method of radium followed by x-ray therapy. There are some exceptions to this procedure, particularly in cases that have large fungating tumor masses extending into the vaginal cavity. In such cases we begin with deep x-ray therapy first. If the fungating mass is extensive and bleeds profusely we remove all or a large portion of the fungating tumor mass by electrosurgery in order to bring the hemorrhage under control and also eliminate a great deal of the infected surface of the tumor. This makes the application of radium much simpler, and one can judge more readily as to the adequacy of the dosage to be administered. Much of the criticism that has been made concerning radium and x-ray therapy, considering the end results, is unjust. One must realize that surgery as a whole has failed to produce many cures, considering all types of carcinoma of the cervix; whereas, with the addition of both x-ray and radium the number of cures have increased more than double, according to the statistics of well-organized clinics over the country. The mortality itself is relatively nil with x-ray and radium; whereas with surgery, even in the most expert hands, the minimum recognized statistical reports show a mortality rate of ten per cent, and this varies up to twenty-two to twenty-five per cent. Therefore, from a comparative and practical point of view there should be no question in the minds of the profession as to the ideal procedures in the treatment of these cases. Radium and x-ray also has its limitations, as has surgery, but from these remarks it becomes evident that the limitations are less than in surgical procedure, both from a morbidity and mortality point of view.

Just as it is essential to thoroughly remove the diseased tissue surgically, so is it also necessary to thoroughly radiate the malignant tissue if one is to destroy it. Thoroughness of procedure is just as essential in one as it is in the other, even if the thoroughness should eventuate in complications. I believe thoroughness is the lesser of the two evils with the present methods at our command. Radium or x-ray used as a therapeutic measure, is, in my humble opinion, not responsible for many of the complications or sequelae, especially in advanced cases. With the better understanding of the handling of radium and deep x-ray therapy and improved surgical judgment, one sees fewer complications today than five or ten years ago. In types three and four one will see the extension of the malignant process to the neighboring organs in most instances. The extension to the broad ligament and about the ureters often causes obstruction and dilatation of the ureter above this point, with secondary involvement of the pelvis of the kidney and the kidney itself, which finally results in the death of the patient with uremia. This is the customary outcome in most of the cases of type three and four. The ureter wall itself is rarely directly infiltrated. Next, we have involvement of the rectum with the formation of a rectovaginal fistula; and third in frequency, the involve-

ment of the base of the bladder with a vesicovaginal fistula. In cases of extensive involvement of the cervix, particularly where the glands are involved, we find secondary constriction of the iliac vessels on one side or the other, resulting in a thrombophlebitis with marked swelling of the entire lower extremity. This seemingly is more frequent on the right side, averaging in our experience about four times more frequently on the right than on the left. Nowadays one rarely sees either a rectovaginal or vesicovaginal fistula directly attributable to either x-ray or radium therapy. I attribute this to the better understanding in the handling of radium and x-ray. Fistulas following x-ray or radium therapy are extremely difficult to reconstruct due to the extent of destruction and the variable extent of ischemia of the tissue surrounding the fistulous tract. This makes it a real ardous task, from the standpoint of reconstruction to a relatively normal-functioning state. Occasionally following the institution of radium and x-ray therapy one will find that the patient progresses favorably for a period of about three to four months, or even ten months, and then suddenly a history of bleeding from the rectum is obtained. Previous to the bleeding there may or may not have been some rectal or lower abdominal tenesmus, with or without dysentery. These are complications that are apt to arise following this type of treatment. With no improvement in symptoms within a period of three to four weeks, it is advisable to perform an exploratory. One will invariably find involvement of the upper part of the rectum or the lower part of the sigmoid, with definite ulceration and a possible perforation. In the past five years I have seen four definite perforations which were fortunately recognized early enough to avoid further complications or sequelae. The ulcerated area is inverted by purse-string sutures, reinforced by a second line of Lembert sutures, and then covered by either omentum or the adjacent epiploica. In two of the cases there was a localized abscess in the pelvic cavity, and this was drained by a posterior colpotomy for a period of seven to eleven days in addition to the above-mentioned procedure. All of these four cases recovered, two of them with a relatively stormy session over a period of three to five weeks with no evidence of any fistulous tract remaining.

A complication which has been reported in recent years, chiefly following x-ray therapy, is that of dilatation of the colon, involving not only the large but also the small intestine. In most instances this condition recedes over a period of four to ten months, according to those who have made a thorough study of this complication. Subjectively, the patient complains of a sense of fullness and loss of appetite, with varying periods of dysentery and constipation. The symptoms are further aggravated by the various foods and vitamin deficiencies as a result of improper absorption power of the gastro-intestinal tract.

A few instances of decalcification and rarification of the pelvic girdle have been observed. Secondary anemia in varying degrees prevails in most of the cases, but this can usually be controlled by either blood transfusion, proper diet, or iron therapy.

After having performed all the necessary therapeutic measures for the immediate benefit and cure of the patient, a thorough routine follow-up measure should be instituted. Each case should be handled individually, but for practical purposes a definite routine can be laid out in most cases. Most authorities agree that follow-up should continue for a period of approximately five years. The intervals of follow-up should vary somewhat, from two months to six months, to be of any practical value from a statistical point of view. Wherever possible, follow-up examinations should be performed by the clinician who treated the case; especially is this important for the first six to twelve months. Within two to four months following either surgical, radium, x-ray or combined therapy it is usually expedient to have a thorough cystoscopic and proctoscopic examination done even though no symptoms may be present at the time. In many instances one is surprised at some of the sequelae detected, and can thus avoid further complications by adequate methods of treatment. Through such maneuvers one is apt to detect conditions either of minor or major importance, which are relatively symptomless to the patient, but which may be of major importance in the ultimate cure of her malignancy. It is unfortunate that too many patients with malignant conditions are treated too subjectively without a thorough objective study. Too many cases are given palliative treatment on the slightest pretext of subjective symptoms. Sedatives do have their distinct place in the treatment of these unfortunate individuals, but they have a limited field in their usage. In some cases one has to treat and contend not only with the malignant phase of the disease, but also with the secondary influence of morphinism. The excessive use of this drug in due time induces its own trail of a disagreeable and obnoxious picture. This latter state of affairs can be avoided in most instances by a more thorough study of the personality and by creating a sense of confidence and courage within the individual.

A rather original and interesting study by Dr. Margaret Sturgis, of Philadelphia, that was started by Dr. Flanagen, was a study of 1,315 volunteers who presented themselves without any pelvic complaints. These volunteers were examined every six months for the past three and one-half, and now close to four, years. The purpose was for cancer-prevention research. At the first examination they found four cases of early cancer of the uterus, one of the body, and three of the cervix. Two of these cervical cancers were found on microscopic examination of tissue removed by trachelectomy for cervical erosion, and the third was found on microscopic examination of a suspicious area. All three cases had developed in areas of cervical

erosions, which substantiates the opinion of the potential seriousness of cervicitis with erosion.

Cervicitis with erosion was found in 227 cases; cervicitis with eversions in 20; cervicitis with cysts in 4; and simple cervicitis in 34, making a percentage of 29.8 women with inflammatory lesions of the cervix. Some of the other lesions found were: papillomas of the cervix, 1; leukoplakic areas, 6; polyps, 64; myomatous tumors, 101; and ovarian cysts, 14. This work has revealed definite results in cancer prevention, in the author's opinion. These researchers feel that nothing short of semi-annual examination of all women of cancer age will pave the way for successful control of cervical cancer.

CONCLUSION

To summarize, the problem of lowering the mortality rate of malignancy of the cervix (in fact, to be exact one should say, "malignancy in general") rests upon the shoulders of the medical profession. This can be accomplished, first, by education of the public, which is being done with increasing fervor through the Field Army of the American Cancer Society. Second, by proper and thorough examination of the patient when she presents herself; supplemented in every instance where any suspicious tissue prevails by removal of some of the tissue for microscopic study. Third, by institution of proper and adequate therapeutic measures following a thorough study of the case. Each case should be individualized. Fourth, by building up the patient's resistance following the institution of therapeutic measures. Fifth, by a complete follow-up of the patient for a period of five years, or more if necessary.

METASTASTIC CARCINOMA AFTER FORTY YEARS

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The following case is reported as a matter of record because of the rarity of the condition.

The patient, an unmarried woman of seventy, first consulted one of us (W.R.D.) in January, 1942, because of a small lump on the left side of the neck, which caused pain in the left shoulder when she turned her head to the right. There was a mass about 1 cc. in diameter at the base of the sternomastoid muscle, apparently coming from behind the muscle.

Her family history was negative, but her personal history revealed that in 1902 both breasts were removed because of cancer. The diagnosis was confirmed microscopically by a pathologist, Dr. Delafield, of New York City. Both the surgeon and the pathologist are deceased. A letter to the Columbia University Medical School, Department of Pathology, brought the statement that "the records and slides prior to 1906 had not been kept," but that "if Dr. Delafield had made a diagnosis of carcinoma, the diagnosis might safely be assumed to be correct." A few years later she moved to California where a hysterectomy was performed because of fibroma. She had an active and busy life, and had traveled extensively in this country and in Europe. She returned to this city in 1940.

General physical examination revealed nothing of additional significance. The head, chest, abdomen, and extremities were negative except for absence of both breasts. In consideration of the history of carcinoma of the breast, I advised excision of the small mass for examination.

Under cervical plexus block I found that this was an extension of a larger mass about 5 by 1 cm. back of the sternomastoid muscle. During blunt dissection she suddenly complained of pain in the left deltoid muscle, and it was evident that this was caused by pressure on the brachial plexus. Injection of novocaine into the plexus promptly relieved the pain, and the removal was completed. This mass was slightly curved and had a very thick fibrous capsule about 2 mm. thick. The microscopic report of this mass will be quoted later. A thorough exploration of the supraclavicular space was made and no other masses were found.

Her progress was uneventful, and a year later, almost to a day, in January, 1943, she again came to me, complaining of two small masses about ½ cm. in diameter, lateral to the point of the former mass. I removed these masses and again explored the supraclavicular space. Microscopic examination showed the same condition as at the previous examination. She was well until December, 1943, when she began to have an obstinate cough which was not severe, but which was non-productive. Treatment proved to be of no avail, and she was referred to a laryngologist and also to a physician who specializes in chest diseases, but nothing could be done to give her relief. The cough became worse and she began to lose weight slowly. X-ray of the lungs revealed nothing of value.

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All this time I believed that there was pressure on the trachea or bronchus caused by a growth in the mediastinum, since it seemed reasonable to assume that if she had malignant lymph nodes in the neck there must be involvement in the mediastinum. She was referred to a competent bronchoscopist, who found nothing abnormal except injection of the mucosa of the trachea and primary bronchia. In June, 1944, she was referred to Dr. Evarts W. Graham, of Saint Louis, with a complete history of her case and a diagnosis of mediastinal carcinoma, who concurred in the diagnosis and advised no operative treatment. After her return home the cough remained very severe. It did not have the characteristic brassy sound of recurrent largyngeal involvement; neither was there any evidence of pressure on the larynx. During the fall of 1944 it was very difficult for her to retain food at times because of the vomiting which followed the severe attacks of coughing.

In December, 1944, a definite sign appeared in the thorax for the first time. A small area of flatness was found in the upper left interscapular space, extending downward along the medial border of the scapula over an area about 6.5 cm. long by 2.5 cm. wide, with no lung sounds coming through. During the next few months this mass steadily increased in size.

In January, 1945, the heart sounds were very much louder and the apex became displaced to the left. The sternum then began to change in shape, assuming a "pigeon breast" appearance, a condition which slowly increased. She was then rapidly losing weight, and during the latter part of February she developed orthopnea at times. During the spring of 1945 there were periods of one to three days when she coughed very little, and occasionally the orthopnea disappeared for a few days at a time. In August, 1945, she died, and a necropsy was performed by us.

The pathology report (by A.W.R.) follows:

GROSS EXAMINATION

The body is that of a white woman sixty-one inches in length and an estimated weight of eighty pounds. Generalized emaciation is quite marked. The scalp is covered by gray hair. Anterior bowing of the sternum is present. No other anatomic deformity is recognized. There are ancient scars:

1. Right and left mastectomy.
2. Left supraclavicular.
3. Midline suprapubic.

Abdominal and thoracic examination was made. Significant findings are limited to the thorax. The anterior mediastinum is filled with a brittle, hard, scar mass which extends into the adjacent anterior margin of each lung and is densely adherent to the sternum, the pericardium, and all of the mediastinal structures, forming a very tough investment about the ascending aorta and the aortic arch. It tends to taper upward toward the junction of the medial and middle one-third of the left clavicle (the site of previous lymph node biopsy). Nodules of similar appearance and consistency (diameter up to 5 mm.) appear on the right parietal pleura near the midclavicular line and are also scattered somewhat over the visceral pleura of the right lung.

In view of the malignant lymph nodes in the left supraclavicular space—the sentinel glands—particular search was made for malignancy in the abdomen. There were no enlarged lymph nodes; the liver was smooth at all points, with no nodules. The stomach and duodenum showed no evidence of cancer. The remnant of the cervix resulting from the supravaginal hysterectomy was a small atrophic bit of tissue. All evidence of cancer was found only in the thoracic cavity.

MICROSCOPIC EXAMINATION

Various sections taken from the mediastinal mass and the adjacent lung tissue show the characteristic picture of small masses of densely staining cells. The nuclei are hyperchromatic and do not exhibit marked variation in size. Mitotic figures are not recognized. It is questionable if there is any demonstration of alveolar arrangement, the cells usually appearing as solid masses. The neoplastic cells sometimes appear in lymphatic vessels. In the lungs they occasionally appear to lie free within an alveolar space. In some places there is close resemblance to the cells which line nearby alveoli. The latter cells present a somewhat different appearance than those seen in more distant alveoli.

Definite identification of the primary site seems impossible. There is considerable cytological resemblance to both basal cell carcinoma of the skin and intraduct carcinoma of the breast.

Sections are re-cut and freshly stained from the blocks of the biopsy specimens of 1-26-42 (S.M.H. No. 19608) and of 1-19-43 (S.M.H. No. 21404). Comparison of these with the postmortem specimen leaves no doubt that the three represent a single neoplastic process. While in the absence of sections from the original mastectomy no similar conclusion in relation to it is justified, the type of neoplasm is suggestive of primary origin in the breast. I have considered the possibility of a carcinoma of the lung (including the alveolar type), but do not believe that there is acceptable basis for such a diagnosis.

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CANCER OF THE MIDDLE EAR: REPORT OF FOUR CASES

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Medical literature has a paucity of articles concerning cancer of the middle ear, and large texts devote a page or less to the subject. The reason for this apparent neglect is the relative infrequence of cancer of the middle ear and mastoid process.

These cases are presented in an effort to swell the number of reported cases of cancer of the ear. Including the external ear, there have been a total of thirteen cases of malignancy of the ear since 1936 at the Indianapolis City Hospital. Three of these were basal cell; two were combined basal cell and epidermoid; seven were epidermoid; and one was a case of hemangio-endothelioma. The following four case histories are those of malignancies of the middle ear. It is interesting to note that three of these came to the hospital in the last year.

Case I—B. M., No. 84530, colored female, aged forty-two: The patient was first seen April 25, 1939, complaining of deafness and of a noise in her ear. A small tumor was seen on the posterior half of the drum, and a biopsy was attempted unsuccessfully. The tumor increased in size, and the ear became painful and began to discharge. The hearing was lost. A radical mastoidectomy was performed September 22, 1939, but no microscopic study was made of the large polyp which bled profusely when it was removed from the middle ear. On July 1, 1940, a freely bleeding polyp was seen filling the mastoid cavity and ear canal. Five hundred ten r. units were given to the ear in three doses of 170 r. per treatment. Three months later there was a throbbing fullness in the ear. The tumor had not regressed, so the mastoid was again operated on and a pedunculated growth was removed from the mastoid cavity. There was free bleeding. The microscopic examination revealed many vascular channels of capillary size and larger in the fibrous tissue of the specimen, and a diagnosis of hemangio-endothelioma was made. The patient was treated with 3,300 r. units through two ports, anteriorly and posteriorly, to the ear.

The patient has not complained of her ear since June, 1941, except for occasional hemorrhages. She is now undergoing treatment for central nervous system lues.

Case II—I. R., No. 53737, white female, aged twenty-eight: On July 8, 1944, this patient came to Ear, Nose and Throat Clinic complaining of pain in her bad ear, which had been discharging since she was a very little girl. X-ray examination revealed only "chronic mastoiditis." Three weeks later the patient returned complaining of dizziness and vomiting. These symptoms were attributed to her state of three-months' pregnancy.

When the patient was next seen, six weeks later, she had a growth in her ear. This firm polyp was removed and sent for routine microscopic study. The electrifying report of squamous cell cancer, Grade IV, stimulated investigation and intervention. A history of facial paralysis of three months' duration was obtained, a finding which she had concealed from us by assuming a shy behavior and talking into a handkerchief. A radical excision of the mastoid and petrous temporal bones was performed by way of an endaural incision. The surgery was brought to an abrupt stop by the appearance of cerebrospinal fluid in the operating field after several square centimeters of dura had been exposed along the tegmen tympani. The patient made an uneventful recovery and left the hospital twenty days after surgery, feeling fine. X-ray therapy of 4,000 r. was given to the patient in slightly more than a month's time at 200 r. per treatment. She had changes in personality, headaches which increased in frequency and severity, and severe pain in her ear. She was readmitted on November 12, 1944, because of her pain. The uterus indicated the baby had reached viability, so every attempt was made to postpone the certain death of the patient. She went rapidly downhill and died twelve days after admission. A postmortem cesarean section was unsuccessful.

Autopsy revealed direct extension of the tumor through the temporal bone and dura to involve the brain. No other extension or metastasis was noted. The left temporal lobe was larger and harder than the opposite side, and was directly connected with the tumor mass which had grown through the skull. The tumor mass was gray and the brain surrounding it was yellow.

Kline and Kahn tests were negative in 1937.

Case III—C. K., No. 217281, white male, aged sixty-seven: At the time this patient was admitted he felt fine and had no complaints except bothersome bleeding from the tumor involving his left ear. There had been a constant, very mild ringing in the left ear for twenty-five years or more. About eight years earlier a small blister appeared just inside the ear canal. Home remedies did not help, and faithful trips to his family doctor did not effect a cure. Several other physicians treated this patient before admitting failure, and x-ray treatments were given without benefit. Approximately eighteen months before admission the patient discontinued his efforts to get cured and "just let the thing go." By this time the ear canal and lower pinna were involved in a raw-surfaced ulcer which bled at the slightest touch. This began to destroy the ear at an increasing rate.

When he was admitted to the Indianapolis City Hospital tumor ward, only the upper third of the pinna remained. This was set out from the head by a subcutaneous firm mass which was approximately 15 cm. in diameter. The lower ear was absent, and

* From the Indianapolis City Hospital, Indianapolis, Indiana.

in its place was the lateral wall of the tumor. The external canal was lost in the raw, granular surface which bled on slightest trauma. There was no facial paralysis evident; neither were cervical nodes palpable. X-ray showed marked destruction of the mastoid cells extending into the petrous pyramid.

Using electro-surgical technique, an incision was made wide around the tumor, removing the ear and neighboring structures. Then a radical mastoidectomy was performed. Microscopic examination revealed the tumor to be a mixed tumor of basal cell and squamous cell, Grade II, cancer.

Three thousand r. units at 200 r. per treatment were given directly over the wound through a 5 x 7 port. No attempt has been made at skin grafting as the wound is healing rapidly. There is facial paralysis since surgery.

Case IV—C. McC., No. 11058, white male, aged forty-two: This man was first seen in November, 1936, and at that time had a discharging, bleeding ear with a tumor obstructing the external canal. He had had the tragus removed four years previously because of a scaly, scabbing sore. The canal was cleaned of tumor by electrosurgery, but apparently there was a regrowth a little over a year later. X-ray therapy, 2,400 r., was given to the left ear, and 1,300 r. to a left cervical node which apparently was involved. A biopsy showed basal cell cancer. By August, 1938, there was still a palpable node in the neck and an ulcerating ear lesion.

FIGURE I



Case III—Tumor of basal cell and squamous cell, Grade II cancer involving left ear.

The patient left town to use a cancer paste, and when he returned in January, 1940, he had lost the hearing in that ear. There was much pain and the auditory canal was indurated. Supraclavicular nodes would swell and subside on that side. A radical removal of the ear and radical mastoidectomy were performed. Basal cell cancer was found to have invaded the mastoid cells. The postoperative course was smooth and nothing noteworthy was done until October, 1940, when a palpable cervical node was aspirated and basal cells proved to be present.

After five years, on August 22, 1945, the patient reappeared, complaining of pain in the occipital region of the affected side, and of frequent small hemorrhages from the ear. The ear was entirely absent and the mastoid cavity was wide open and for the most part unepitheliolyzed. Beneath the former site of the external auditory canal was a firm elevated tumor 1 x 3 cm., extending down behind the ramus of the jaw. A biopsy from this lesion proved to be mixed basal cell and squamous cell, Grade I, cancer. The face has become paralyzed in the past two years. Further action remains to be taken. Kline and Kahn tests were negative in 1940.

The importance of microscopic study of tissue specimens is brought out in three of these cases. In the first case the correct diagnosis was not made until the tumor had been operated on a second time, over a year after the first mastoidectomy. In the second case the first positive evidence of neoplasm was the report on routine tissue study. In the last case a change from basal cell to mixed epidermoid and basal cell cancer is positively demonstrated.

The early symptoms of cancer of the middle ear are inconstant and may imitate the symptoms of many ear diseases. The early symptoms may be those of external otitis of infectious or allergic origin. They may be the symptoms of acute or chronic otitis media, or possibly the symptoms arising from cochlear or vestibular disease. With such protean symptomatology it is evident that early cancer of the middle ear often will be overlooked. Only when bizarre or unexpected events occur does the true diagnosis suggest itself.

Symptoms which should make one suspicious of cancer of the middle ear are: (1) persistant regrowth of polyps; (2) otorrhea which becomes bloody; (3) unexplained deep pain about the ear; and (4) progression of a common disease of the external or middle ear with the development of unusual symptoms.[1, 2]

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[1] Stokes, H. B.: Primary Malignant Tumors of the Temporal Bone, *Arch. Otolaryng.*, 32:1023-1030, (Dec.) 1940.

[2] Peele, J. C., and Hauser, G. H.: Primary Carcinoma of the External Auditory Canal and Middle Ear, *Arch. Otolaryng.*, 34:254-266, (Aug.) 1941.

The accompanying table is a summary of the cases of cancer of the external and middle ear seen at the Indianapolis City Hospital in the past ten years. The above detailed case histories have been summarized and included in this chart.

TABLE I.

SUMMARY OF CASES OF CANCER OF EXTERNAL AND MIDDLE EAR SEEN AT INDIANAPOLIS CITY HOSPITAL, 1936-1945

Patient	Age	Lesion and Biopsy Report	Treatment	Result
1. C.D., 11655, White female	57	Ulcer 2x1 cm. on pinna. Basal cell ca.	2,000 r. at 500 r. per treatment.	Well healed two mos. later at last contact.
2. J.R., 88108, White male	81	Raised ulcer 2 cm. in diam. on pinna. Basal cell ca.	3-10 mgm. radium needles for twenty-four hrs. (360 mgm. hrs.)	Well healed two and one-half months later at last contact.
3. C.T., 94130, White male	65	Repeatedly-recurring ulcer of pinna and ear canal for six yrs. Basal cell ca.	Over 7,000 r. in five courses of therapy, and six surgical approaches including radical auriculectomy and radical mastoidectomy.	Well healed at present (three mos. after surgery).
4. C.McC., 11058, White male	42	Scaly, scabbing lesion on tragus which spread in spite of therapy to involve pinna and mastoid. Basal cell ca. for nine yrs., then mixed basal and epidermoid ca., Grade I.	Two electrosurgical excisions followed by radical auriculectomy and radical mastoidectomy. 2,400 r. to ear, 1,300 r. to cervical node.	To be treated for last recurrence.
5. C.K., 217281, White male	67	Firm tumor 15 cm. in diam., which destroyed lower pinna and involved mastoid and petrous temporal bones. Mixed basal cell and epidermoid ca., Grade II.	Radical excision and radical mastoidectomy followed by 3,000 r.	Now healing well.
6. S.S., 82608, White female	81	Ulcer on pinna. Epidermoid ca., Grade II.	Electrosurgical removal plus 2,400 mgm. hrs. radium followed by deep x-ray therapy four mos. later.	Two cm. nodule beneath pinna at last contact.
7. R.G., 115556, White male	59	Bleeding ulcer of middle ear, pinna having been removed by pastes. Epidermoid ca., Grade II.	2,400 r. 0.5 cc. marrow three times a week for seven mos.	Extension, facial paralysis at last contact.
8. C.B., 80164, White male	60	Raised ulcer 2½ cm. in diam. on helix. Epidermoid ca., Grade I.	6,600 r. to ear. 2,000 r. to node below angle of jaw.	Healed at time of death from coronary thrombosis seven mos later.
9. F.McM., 1906, White male	62	Nodule ½ cm. in diam. on post. pinna with adjacent keratosis. Epidermoid ca., Grade I.	Electrosurgical removal.	Healed. No cervical nodes ten mos. later at last contact.
10. G.S., 148312, White male	74	Ulcerated nodule 3.5x1.5 cm. on pinna. Regional nodes palpable. Epidermoid ca., Grade III.	6,000 r. to primary tumor. 3,300 r. to cervical nodes. Two mos. later 168 mgm. hrs. radium to cervical node.	Healing ear lesion. Soft, but palpable cervical node at last contact six mos. later.
11. R.R., 157433, White female	78	Large indurated ulcer on cheek which metastasized to regional glands and ear, causing facial paralysis in six mos. in spite of therapy. Epidermoid ca., Grade II.	2,500 r. superficial and 200 r. deep to cheek lesion. Ear excised with electrocautery. Mandibular nerve block.	Extension into nodes of neck, causing severe pain and ulcers at last contact eight mos. after first clinic.
12. I.R., 53737, White female	28	Rapidly-growing tumor of middle ear. Dizziness, nausea, and facial paralysis preceding any external evidence of neoplasm. Epidermoid ca., Grade IV.	Radical excision of mastoid and petrous bones followed by 4,000 r.	Died four mos. later from intracranial extension.
13. B.M., 84530, Colored female	42	Recurrent polyp of middle ear which bled freely when traumatized. Hemangio-endothelioma.	Radical mastoidectomy. Ten mos. later 510 r. Mastoid re-operated and 3,300 r.	Occasional hemorrhages from ear at present, five yrs. since last therapy.

In early cancer of the middle ear roentgenograms are not helpful in arriving at the true diagnosis. This is well demonstrated in Case II. Films taken later in the course of the disease show extension of growth when compared with early pictures.

Treatment of neoplasms of the ear has changed

only a little in recent years. The course usually followed is radical surgical removal followed by irradiation therapy.[1, 2, 3, 4, 5, 6, 7] Figi and Hempstead[8] have discussed treatment of the many neoplasms of the middle ear seen at the Mayo Clinic. They advocate a combination of electrocoagulation, radical mastoidectomy, and irradiation as the most effective way to deal with most neoplasms of the middle ear. The risk of intracranial complications is greatly increased by a conservative approach.

Earlier writers uniformly gave a bad prognosis, varying, of course, with the individual case. Figi and Hempstead show that the prognosis is better than generally thought.

[3] Schall, L. A.: Neoplasms Involving the Middle Ear, *Arch. Otolaryng.*, **22**:548-553, (Nov.) 1935.

[4] Buckman, L. T.: Carcinoma of Middle Ear and Mastoid, *Ann. Otol., Rhin. and Laryng.*, **52**:194-201, (Mar.) 1943.

[5] Grabscheid, E.: Adenocarcinoma Involving Middle Ear, *Arch. Otolaryng.*, **37**:430-433, (Mar.) 1943.

[6] Maconie, A. C.: Sarcoma of Middle Ear and Mastoid, *J. Laryng. and Otol.*, **49**:32-35, (Jan.) 1944.

[7] Furstenberg, A. C.: Primary Adenocarcinoma of Middle Ear and Mastoid, *Ann. Otol., Rhin. and Laryng.*, **33**:677-689, (Sept.) 1924.

[8] Figi, F. A., and Hempstead, B. E.: Malignant Growths of the Mastoid Process and Middle Ear, *Minnesota Med.*, **28**:38-43, (Jan.) 1945.

TRAUMATIC NEUROSIS OF WAR

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We are all familiar with the term "shell-shock," which was applied to a group of psychiatric casualties occurring in World War I.[1] This term referred to those who were hospitalized for a train of symptoms which ensued after exposure to the effects of a shell exploding nearby. This syndrome was characterized by marked tremulousness, headache, disturbance of consciousness (fainting spells), ringing in ears, dizziness, rapidity of pulse and breathing rates, marked sweating, flushing or paleness of the face and hands, and terrifying dreams. In addition, some of these soldiers manifested transient hysterical episodes involving speech, hearing, vision, and twilight fugue states.

Despite the disfavor into which the term "shell shock" fell, it has been recognized that this problem, among other psychiatric disorders provoked by World War I, did a great deal to stimulate interest in abnormal psychology everywhere. Attention to this problem was forced upon the public because of the economic costs (pensions and medical care), as well as the disability which a number of these men displayed for a period of years thereafter. In passing, for example, it might be mentioned that over a billion dollars was spent on these men by the Federal Government up to the outbreak of World War II.

From reports which have been released it is evident that the incidence of neuropsychiatric casualties has already exceeded that of World War I, and there is obvious reason to anticipate a still further increase. The implications are self-evident in posing a challenge to all agencies which must cope with these casualties for some time to come.

The Problem of Traumatic Neurosis of War

The pressure of having to handle a large number of patients in the military obviously necessitates rapid, brief diagnosis and treatment. In the combat zones this pressure has been most intense, and measures were adopted to meet the exigencies of the situation. It is well known that every soldier exposed to the imminence of combat or actual combat will react with anxiety. The manner in which this anxiety will affect him must depend on certain individual factors. The individual must balance his own self-preserving drive against the necessity of preserving the group in face of danger. Anxiety mobilizes all our forces to meet danger, to cope with the threat. But some individuals become overwhelmed, paralyzed by anxiety, and cannot go on functioning.

One of the most distressing and terrible experiences to be endured in combat is shell-blast concussion. Yet we have seen some soldiers survive this terrifying experience with rapid recovery, and resume their attack on the enemy. Others have been so disabled that they required evacuation to the rear. One of the problems awaiting solution is that of determining why one man can "take it" and another can not. Possibly the most fruitful study of the traumatic neurosis of war has been the work of Kardiner,[2] in which he indicates the promise held out by intensive psychotherapy. As in World War I, there has been some

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[1] (a) Medical Department of the United States Army in the World War: *Neuropsychiatry*, Vol I, United States Government Printing Office, Washington, D. C.

(b) Dunn, William H.: *War Neuroses Psychol. Bull.* **38**:497, 1941.

[2] Kardiner, A.: The Traumatic Neuroses of War, Paul E. Hoeber, Inc., New York. 1941.

controversy as to whether or not these traumatic neuroses of war have sustained brain damage as a result of the blast concussion, especially since a number of these patients manifested hearing impairment. The consensus of most observers is that the significant disability is one of psychological trauma—not cerebral.

Illustrative Case Report

The clinical picture is strikingly uniform with characteristic development and symptom complex.

Case history: A twenty-two-year old soldier went overseas in September, 1944, and served as a bazooka man and rifleman for five months of combat in France, Belgium, Holland, and Germany. Early in March, 1945, a shell landed close to him, knocking him out for about thirty minutes (although he is not sure about any of the details that he gave, because everything seemed confused and hazy). He was carried by the medics into a cellar, and manifested marked tremulousness of the entire body and a severe startle reaction. Then he was taken back to the battalion area where he rested for two weeks. After this he returned to the line for two weeks, where he helped to stand guard, set up gun positions, et cetera, but he found that he could not stand the strain of being shelled or being alone at night. While standing guard the soldier became panicky and kept calling out that he saw the Jerries coming at him from time to time. His platoon leader then sent him to the Aid Station, where he continued to have headaches, vomiting, marked tremulousness, palpitation, breathlessness, and startle reaction.

In time he received some insulin at a field hospital, "walkie-talkies" (barbiturate) at an evacuation hospital, and then symptomatic treatment for a "nervous stomach" at a general hospital. Symptoms of marked anxiety persisted, including battle dreams in which he was being killed or about to be killed by an overwhelming number of Jerries.

The patient finally reached this convalescent hospital in May, 1945, with the same complaints, only slightly diminished in degree. The physical examinations, including neurological tests, failed to reveal any evidence of organic disease.

In his background it is significant to note that the patient was the middle of three children; his mother is described as being "an awfully nervous woman." The soldier went to school up to the tenth grade. As a child he was always thin and puny, but he did not seem to ail much. In his childhood and adolescence there was a history of enuresis, nail-biting, temper tantrums, and moody spells. He was fearful of the dark up to the age of twelve. The patient was afraid of his father because of his temper and also of a bullying older brother. The soldier worked on a farm steadily up until the time he came into the Army.

During his early stay at this hospital the patient continued to manifest marked anxiety, and declared that he still experienced terrifying battle dreams of the type indicated above, always with the theme that he was about to be overwhelmed by superior enemy forces. The patient's anxiety decreased steadily with a regimen of narco-hypnosis, group psychotherapy, and regular visits home. He was eventually discharged from the service and able to readjust to a civilian occupation.

Summary

The traumatic neurosis of war is a definite clinical entity which is provoked by shelling or bombing. The disability of the soldier is due to psychological reaction, not to cerebral trauma. This condition is amenable to psychiatric therapy.

(Colonel Selinski's present address is 17 East 96th Street, New York City.)

ABSTRACT

NEW TECHNICS REDUCE DEATH RATE FROM SURGERY FOR CANCER OF LUNG

A Boston physician reports that during the last four years there has been a great reduction in the death rate of patients treated with surgery for cancer of the lung. Over a fifteen-year period he observed seven deaths in nineteen cases of surgery for the first eleven years, and one death in thirty cases in the last four years.

Ralph Adams, M.D., from the Department of Surgery, the Lahey Clinic, Boston, writing in the March 2 issue of *The Journal of the American Medical Association*, credits the lowered death rate to improvements in the preparation for operation, in anesthetic administration, effective closure of the infected bronchus, reduction of shock, eradication of infection, and prevention of the partial collapse of the lung.

The author says that the frequency of cancer of the lung, compared with all other cancer, is between six and eight per cent. The most susceptible age is between forty and fifty. The male preponderance was one hundred twenty-eight to twenty-nine, or 81.5 per cent.

Symptoms of wheezing, shortness of breath, and coughing with or without pus or blood in the sputum are common signs of cancer of the lung. Hoarseness, pain, fever, and loss of weight are less obvious symptoms, but they may occur.

Early cancer of any type is curable, including cancer of the lung, but unfortunately it is often difficult to make an early diagnosis because the symptoms may originally suggest a less dangerous disease of the lung, such as asthma, bronchitis or pneumonia.

Dr. Adams followed one hundred fifty-seven consecutive cases of cancer of the lung at the Lahey Clinic in the fifteen-year period ended December 31, 1944. Of the forty-nine of these patients who underwent surgery, eight died in the hospital. Twenty-three deaths subsequently occurred from recurrence of the disease, while four patients are living with evidence of recurrence. Fourteen patients are alive and well at the present time, with a chance for a five-year survival. The longest survival to date is nine years, according to Dr. Adams.

RESUMÉ OF MEDICAL ACTIVITIES AT GERMAN PRISONER OF WAR CAMP, FORT LEWIS, WASHINGTON, AUGUST, 1944-AUGUST, 1945

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Medical care given to prisoners in a Prisoner of War Camp is just as thorough and painstaking, at least in the United States, as it is when given to soldiers of our own Army. Moral and ethical standards would not admit or tolerate any other type of treatment. However, there is a difference in the mode of offering treatment, necessarily, since certain definite and incontrovertible rules of security apply to prisoners of war. At the same time the medical officer is faced with the responsibility of keeping the largest possible majority of prisoners working. The doctor has a great deal more to do with the above than any other officer in the camp, for there is no way to avoid work other than by actual or feigned illness, and needless to say there are many prisoners that try a hand at malingering.

During the year at the German Prisoner of War Camp, at Fort Lewis, Washington, there arose a multitude of interesting medical and sociological problems. These have been interlarded with events not having an iota to do with medicine, but nevertheless spicing up life with everything from low-brow "Gestapo" drama and persecution to suicide by hanging. During the year accurate files were kept on all medical work, and certain interesting conclusions may be drawn.

In order to understand conditions under which we worked there must be incorporated a short description of the physical properties of the camp and the medical facilities.

German prisoners of war at Fort Lewis, Washington, really are secured in three camps within approximately a twenty-mile radius of each other. The main camp consists of a stockade within which are six compounds, each of which may be made into a separate entity by the mere closure of a gate. Four of these compounds are primarily for living quarters, and also have canteen buildings, theaters, athletic fields, et cetera. One smaller compound is maintained solely for the purpose of isolating prisoners who are being punished and are on a bread-and-water diet. The sixth compound is used as a salvage and repair station, where a large number of prisoners work; this compound having no living quarters but containing mess facilities. Outside the stockade a separate detention building is maintained for prisoners in protective custody. In this main camp there are some eighty buildings, and the large majority of prisoners are secured at this site, the number going to as high as 4,790, with approximately 103 men to a barrack.

Two other smaller camps allow for maintaining approximately 300 and 500 prisoners, respectively.

Medical facilities consist of four dispensary buildings with wards equipped to care for forty-four to fifty patients at one time — laboratory, physiotherapy department, pharmacy, treatment rooms, and offices in which to hold sick call. Two dispensaries were maintained in the main camp, with one each in the other two smaller stockades. A separate office building for the camp surgeon allowed greater facility for maintenance of record files and accommodations for diagnosis and treatment of American personnel. Thus we see that a great deal of distance was to be covered daily not only in attending sick call, but also in routine medical inspection, including seventeen companies and their messes. Separate attention had to be given to men under punishment who could not attend regular sick call, and likewise men under protective custody.

In August, 1944, at the beginning of the assignment of the writer to the Prisoner of War Camp, there were six German medical officers in the camp. Two of these officers were old enough to have practiced in Germany before the war. The others were more or less "war doctors," and had a sketchy education. Here I should interpose the observation that the standard of all six of the doctors was far below American standards of medical education and practice. Furthermore, all but one were constantly up to their Nazi necks in petty but nasty intrigue which constantly kept some aspects of medical work in a turmoil until quite a firm hand was used in restricting their activities in one way or another. At the end of a year only two officers were left, and more or less of an even keel was maintained by a little constant pressure by the writer.

It was found after a few days' observation that the German medical officers could not be fully trusted either with diagnosis or treatment, and could not be trusted at all with the responsibility of marking a man either "quarters" or "duty," since the disposition would always be "quarters" when a man merely appeared on sick call even though there was absolutely nothing wrong with him. Naturally, we understand that we would do the same for our own men if we were in the same position as these German officers, provided we could get by with it. If a man can be marked "quarters" for a day or longer he automatically is kept in from his work detail, and quite assuredly that appeals to any prisoner.

Therefore a system had to be worked out whereby sick men could receive good medical care and malingerers would be sent to duty immediately. To this end a plan was set up whereby the German

medics saw everyone on sick call first and screened them, so to speak, sending only those that they thought were really sick to the camp surgeon. For the first few months the number sent to the writer was high and contained innumerable "gold bricks" as well as those really needing attention. The German medical officers were not allowed the privilege of marking anyone "quarters." Gradually, when it became apparent that it availed them nothing to send healthy P-W's to the surgeon, the German medics began marking them "duty" themselves, thus decreasing the initial load tremendously. This also had a beneficial effect on the total sick call, for as soon as the prisoners of war found that their own officers were sending the gold bricks to duty few came that were not really in need of medical care.

Now I will digress and cover somewhat more completely the subject of malingering among prisoners, and how it was stopped almost 100 per cent.

It is obvious that the essential function of American personnel associated with a prisoner of war camp, after security measures are taken, is to keep prisoners working. It is needless to discuss the well-known reasons for working prisoners, except as it affects their physical and mental well-being. From the medical standpoint alone it is essential that prisoners be kept occupied as many hours as possible, both with work and with activities outside working hours which are of interest to the prisoners; hence, athletics, art of various kinds, and hobbies are encouraged, for no matter what the mental make-up of the man is, the mere fact that he is incarcerated for an unknown length of time tends toward some degree of psychoneurosis. Thus, resorting to occupational therapy as a prophylactic measure is indeed good.

In order to keep the largest possible percentage of prisoners working, several factors must be borne in mind, such as the time details start work, transportation to and from work, and methods of stopping malingering.

The normal sick call in the Army is scheduled for eight A.M., but in the prisoner of war camp prisoners are expected to go on work details much earlier. Therefore, if sick call is held at the usual time there is an opening for men to avoid going on their detail for the day by remaining for sick call. Since transportation is usually acutely short it would be impossible to pick up all these men and take them to details which were already at work, and which were spread over the length and breadth of the post. The only remedy for this is to hold an earlier sick call, and so our day starts at 6:00 A.M. —two hours earlier than usual. By the time the details leave a large majority of new patients have been seen and sorted as to need for treatment. Older patients who were already on quarters status are reserved to be seen last. After disposal of those marked "duty," the remainder of the men may be examined and treated more fully. Elimination of a man whose sole idea was to appear on sick call to miss leaving on detail was then fairly complete. Sick call totals dropped somewhat, but still there were men slipping by.

On further observation it was found that many men were being sent from the dispensary early enough to go out with details, but were delaying in returning to their companies, stating to the company personnel that they just returned from treatment. Immediately a plan was initiated whereby each man coming on sick call had to have a comprehensive mimeographed form which allowed space for disposition, whether duty, quarters, or hospital; clinic appointments; time left dispensary; signature of surgeon; and time returned to company. An elapsed interval of five minutes was allowed to traverse the distance between dispensaries and the companies. This program resulted in many more men leaving with details on time, and a further decrease in total sick call.

It was felt by the writer that a cut could still be made in noneffectives. There were cases with minor wounds or vague complaints but in need of more complete check who were enabled to get out of work for the day because of time consumed in treatment or some diagnostic procedure. These men could work, but because of transportation difficulties could not be taken out to their regular details. This encouraged the tendency to come on sick call with complaints so minor that one would ordinarily disregard them. So the "wood pile" was originated. If a man was too late for his regular work, and still had a legitimate excuse for being late, but was marked "duty," he spent his normal working hours sawing and chopping wood, or at other such occupations. The effect of this stratagem was startling in its reduction of numbers on sick call. From this point on malingering was reduced to a minimum and considerable more time could be given to those men who were honestly in need of attention.

The following work covers the main camp only: During the year August, 1944, to August, 1945, the total number seen on sick call was 30,934, which gives an average of 84.75 men daily; however, it will be seen that during the first part of the year the number was much higher, and in the latter part of the year much lower due to the efforts described before to limit the number of gold bricks. The results are graphic when the total is divided into thirds of a year:

Total cases on sick call first three months	10,352.
Total cases on sick call second three months	9,098.
Total cases on sick call third three months	6,885.
Total cases on sick call fourth three months	4,599.

Likewise the number of man days on quarters showed the same trend:

Total man days on quarters first three months	5,473.
Total man days on quarters second three months	4,307.
Total man days on quarters third three months	3,821.
Total man days on quarters fourth three months	2,352.

So in the first three months there was an average of 115 men per day on sick call, and 60.8 men per day on quarters; while in the last three months there was an average of 50.1 men on sick call, and 26.1 quarters cases. It is assured that the large majority of men in the later periods were definitely ill and were not malingering in any sense. This is obvious when we see that half of all men on sick call were put to bed in either their own quarters or in the dispensary wards.

In a division of cases requiring treatment either in dispensary wards, quarters, or in a general hospital, a classification according to disease or injury may be made as follows: (Some classes deserve comment.)

Fractures totaled thirty-seven, with twenty-three of upper extremities, nine of lower extremities, three skull, and two pelvic fractures. The skull and pelvic fractures were due to truck accidents which occurred while transporting prisoners of war, while of the remainder, fourteen were due to accidents in playing soccer, and the rest were incurred due to work accidents. All made good recoveries with the exception of two. One, with skull fracture, developed a post-traumatic cerebral syndrome and was repatriated. The second, with skull and pelvic fractures associated with rupture of the urethra, was repatriated with an additional diagnosis of active pulmonary tuberculosis.

A high percentage of fractures was due to accidents incurred while engaged in sport activities. Naturally, fracture cases require long periods on quarters status and many man-hours of work are lost. However, the advantages of having athletics as regards mental and physical health definitely offset the disadvantages.

In comparison with a like number of American soldiers engaged in similar work and sport activities, it is believed that the per cent of fractures of German prisoners is much higher. Definite figures on this have not been worked out, but previous experience with American soldiers over a two and one-half year period is used for comparison.

Cases of malarial fever did not occur to any marked degree. During the year's period there were twelve patients with malaria—all of the tertian type. Among the twelve cases there were seventeen recurrences. All were treated solely with atabrine, and there were no instances of enlargement of the liver, and no anemia. Since almost all of the prisoners here were Afrika Korps men it is believed that this represents a low average for malaria. All prisoners newly admitted to the prisoner of war camp had an initial smear for malaria whether or not symptoms were present, and whether or not a negative history was obtained.

Disease entities found in abundance, and which possibly resulted because of these men having been in Africa, were intestinal parasites, Trichuris trichiura, Giardia lamblia, Ascaris lumbricoides, oxyuris, Endamoeba buetschlii, Hymenolepsis nana, Shigella alkalescens, Shigella paradysenteriae, Shigella ambigua, Endamoeba nana, taenia, Endamoeba histolytica. Of these, Endamoeba histolytica was the most vicious offender, comprising some forty per cent of the total. Altogether there were some eight hundred positive stools obtained which comprised positives of the entire group, some being nonpathogenic and not requiring treatment. The same principle used in malaria smears applied here; that is, stool specimens were obtained from each incoming prisoner. Since a high percentage of amoeba existed, great care had to be exercised in checking food handlers. Stools were obtained from food handlers every thirty days until six stools were consecutively negative. It is interesting to note that studies made on two groups of men showed that although stools were negative on two occasions, on the third stool specimen a third of the total number was positive. These studies were carried out on one hundred sixty-seven men; thus it can be seen that caution had to be used in clearing a man for food handling. During three months of the year a group of 106 Russians were studied. These men had been in Germany and France after coming from Russia and were captured with the Germans in Normandy. Of the 106 Russians, there were 105 who had positive stools. Of these 104 showed more than one parasite, and fifty per cent were positive for Endamoeba histolytica. This was a much greater incidence of parasite infestation than was found among the Germans that accompanied them.

One of the most aggravating causes of morbidity among the prisoners was furunculosis. It appeared in all its vicious and incapacitating forms. Furuncles were almost without exception of a widely-indurated, deep-seated variety. In a large majority of patients there was a generalized furunculosis which defied any and all treatment to a great extent. Several cases were hospitalized for penicillin therapy; others received autogenous vaccine, and the remainder had routine treatment. Without exception the patients treated with penicillin and autogenous vaccine had recurrences of generalized furunculosis. For the year there was a total of 564 men incapacitated due to this disease. At times the percentage of men presenting themselves on sick call due to one or more furuncles was 13. In comparison with a like group of American soldiers with similar occupations this is terrifically high, since in the American group the figure is less than one-half of one per cent. No conclusions could be drawn. All types of therapy, including vitamin, were used, and all met with little success. No differentiation between German and American men could be made as to cleanliness, skin irritation for various causes, or occupation.

One great difficulty that had to be fought constantly was the propensity of the German medical officers for using ichthyol in great quantities on all furuncles. Frequently cases would be seen in which the furuncle had ruptured and was draining a large quantity of laudable pus which was thoroughly mixed with widespread ichthyol and consequently covering the adjacent several centimeters

of skin. It was found that the German medics were great believers in using ichthyol plentifully for not only furuncles but for sprains, effusion of the knee, baldness, and occasionally as chest plasters for bronchitis. It was concerning furunculosis we were talking to the German medics one day, to obtain their knowledge about the incidence of this disease in the German army, that the following startling intelligence was gained: two of the best-educated medics stated that the incidence was much lower in the German army at home, and that it was their belief that the very high incidence here was due to the fact that the men could not be with their wives or girl friends. In all seriousness they said that it appeared that an over-engorgement of the seminal vesicles had dire results as far as boils were concerned.

Another factor creating a high degree of incapacitation was sprains and strains. A total of 774 was found for the year, divided roughly into twisting or like trauma of the knee, with subsequent effusion in 109; sprains of ankle, 192; and sprains of back, arms, shoulders, et cetera, 474. Etiologically, all cases could be divided into two groups, which were almost equal: 1, those due to jumping from trucks when men were transported to or from details; and 2, those due to athletics. In the latter months of the year, due to the fact that we called their attention to accidents incurred during the process of transportation, this incidence fell, and the preponderance then became that due to sports, of which soccer played the biggest part. It is our estimation that soccer—as played by German prisoners here—is a greater injury-producing instrument than football as played by American men.

One of the most interesting medical problems encountered was that of genito-urinary disease. A total of 68 cases was seen, of which 55 were hospitalized. One patient with tuberculosis of the kidney caused some baffled days before we arrived at a diagnosis. Repeated smears of urinary sediment first told the tale, following which guinea pig innoculation and other examinations were conducted. Of the remaining patients hospitalized the diagnoses were as follows: albuminuria, 22; hematuria, 10; pyelitis, 4; nephritis, 12; and renal calculus, 6. Of the cases with renal calculi there was one nephrolithotomy accomplished, to my knowledge. This patient had infrequent and mild symptoms subsequent to surgery. Again we see a higher incidence of a particular disease in this German group than in a like group of American men. We may theorize on the fact that these men went through long periods in Africa without being able to obtain a normal water supply. From histories taken it appears that there was often a marked degree of dehydration prevalent in the course of their desert travel. Along this same line it was ascertained that their food and sanitation fell far below normal standards.

Patients with psychoneurosis and psychosis presented one of the most difficult problems of diagnosis and treatment. Two cases that were psychotic were hospitalized and subsequently transferred to a German general hospital. These were comparatively no trouble; however, the psychoneurotics, numbering nine, were a far different matter. Of the nine, there were five cases in which it was felt that actual and vicious persecution played a major if not a controlling part. In these latter cases we had to rely on information gathered from interpreters who worked in my office. These men were found to be trustworthy and not afraid to give information even though it implicated other prisoners and brought up the possibility of future retribution if they were suspected. Here, instead of suspecting schizophrenia when a patient would talk, as some did, of being persecuted, the opposite would hold true. The story of persecution was held to be true until proved definitely false. Here the interpreter played a most important part in that he usually already knew something of the facts, or if he did not know he soon found out. It is surprising how much knowledge two or three prisoners gain about the rest of the personnel in camp, even though there be almost six thousand men.

The so-called "grapevine" functions superbly. Three patients came to my office at different times in such a state of mental anguish that they trembled, cried, and were unable even to speak until some time had elapsed. They were pictures of abject terror, and were literally "scared to death." Even with such close association as exists between doctor and patients, even though they be prisoners of war, it is difficult to imagine the effect of persecution as it existed.

The pro-Nazi element found many reasons to persecute others. A few are listed: 1. Anyone not a pro-Nazi. 2. Receiving mail from relatives in this country (this was illustrated by one patient who had two relatives in the United States—he was told that because he received so many letters he was becoming Americanized, and therefore was a traitor). 3. Being honest (if a prisoner of war was honest in answering questions by American authorities he was considered a traitor). 4. Doing too much work on a detail (this made a bad example of the others). 5. Merely being disliked by one of the German medics or the camp spokesman, for no reason at all, led to circulation of false rumors about the individual, and thus persecution. There are many other reasons we could cite that were used, but suffice it to say that all were a product of Nazi-taught minds.

The type of persecution took various forms, but most of them followed a definite pattern. A fairly good example may be given by using the case of one of the aforementioned interpreters. The man in question was one of the best (I was especially fortunate in having three such men). He had been a medical student before the war and was above the average in intelligence. More important, he was honest. His and another interpreter's honesty was borne out by the following incident which I learned after some months. The two men were called in to

the senior German medical officer's room and told in no uncertain terms that they were to interpret each patient's complaints in such a way that it would lead the American doctor to believe the patient to be much too ill to work, and thus get the patient marked "quarters." Enough of these, and work is slowed tremendously. The men flatly refused to carry out such a scheme. This naturally incurred the wrath of that particular Nazi, and he tried in many ways to get these two in trouble with their comrades. It was as a result of this that the one was involved in many heart-breaking events before it ended. On Christmas eve a group of men paid him a call in his barracks and proceeded to tell him several things—that he kept them from getting quarters, from obtaining light duty details, from changing details, and that consequently he was a traitor.

They said he was Americanized, and that they were going to kill him. It is hard to imagine what ones feelings would be in such a predicament—the men that pass you when you're walking, whisper, "traitor"; eyes follow you; dark corners and sides of buildings are to be avoided; and you hear, "we'll kill you, we'll get you when we are ready." All this time, remember, you are enclosed in a stockade; there is no place to go, nowhere to escape. There is only one solution to the problem, and that is to ask the authorities to remove you from the stockade and place you in protective custody. Sounds simple, doesn't it? However, another terrifying problem is to be faced. If you once leave the stockade under such circumstances you will be branded as a traitor not only by your former antagonists, but also by the friends you had. No one will henceforth accept you as a German. Because of this fact you try to fight it out mentally, and one of three things may happen: one, there is a possibility of your being murdered; two, you break mentally; or three, you are made of sterner stuff and lucky enough to outlive the strength of the rumor. Fortunately, the latter was the outcome in the case of the interpreter. Some others were not so lucky Of the five men, one attempted suicide, and four were classified as psychoneurotics and were sent to a neutral country for hospitalization. The fifth, after a period of hospitalization, was able to again resume life with the other prisoners. Four other cases which we believed to be due simply to their life as prisoners of war were able to carry on after hospital care.

Patients with war wounds sufficiently severe to bring them to sick call totaled 134. Some forty cases were admitted to this camp directly from Normandy with wounds that required a great deal of attention. The others were wounds that caused varying degrees of disability and required placement of some men on light duty details. There were a number of cases that had not had shrapnel removed, and some of these developed symptoms and findings which necessitated removal.

A simple tabulation of wounds acquired is as follows:

GRENADE WOUND

Shoulder	3
Arm	6
Chest	2
Abdomen	5
Thigh	11
Leg	12
Knee	6

GUNSHOT WOUND

Head	10 (3 with absence of bone)
Arm	25
Abdomen	2
Thigh	40
Leg	4
Knee	5

SHRAPNEL WOUND

Face	3 (with loss of one eye)

FOREIGN BODIES

Chest	8
Arms	7
Hand	1
Thigh	3
Leg	2
Knee	3
Foot	2

A summary of other diseases and injuries seen during the year are as follows:

1. Upper respiratory infections, 1,515. At one time it was feared that upper respiratory infections might break bounds since the incidence was higher than an average incidence for all American soldiers at Fort Lewis, and since there was an average of one hundred three prisoners quartered in each barrack. However, the period passed without the development of a high incidence of morbidity.

2. Ruptured nucleus pulposus, three. It was discovered on ward rounds with the German medical officers, on the occasion of tentatively diagnosing the first case, that not one of the six had the slightest idea as to what was meant by intervertebral disc rupture, nor any of its symptoms or signs. This was another example of highly-touted German doctors not living up to previous claims.

3. Tuberculosis, eight. Here were three cases of active pulmonary tuberculosis, four arrested cases and one before-mentioned case of genito-urinary tuberculosis.

4. Syphilis, three. Two cases had received some previous treatment. The third had had no treatment and was allegedly unaware of chancre or secondary lues.

5. Peptic ulcer, five.

6. Diabetes mellitus, one.

7. Jaundice, eight—unclassified.

8. Pneumonia, five.

9. Pleural effusion, thirteen.

Deaths from all causes for the year totaled three, one from pulmonary tuberculosis and superimposed pneumonia, Type XVII; one from coronary occlusion; and one due to strangulation by hanging.

The latter death was of one of the German medical officers, a young obstetrician and gynecologist. It may be of some interest, in passing, to note that he was an Austrian, and had a father and brother practicing medicine in Vienna.

As mentioned in a cursory manner before, there was a laboratory, some physiotherapy facilities, and, of course, treatment rooms where all dressings and minor surgical procedures were carried out.

The laboratory was equipped to do all examinations with the exception of cultures, blood sugars, Wassermanns, and other more delicate tests. The majority of examinations were of a simple type, as follows:

1. Gastric analyses, 119.
2. Urinalyses, 2,015.
3. Blood counts, 1,187.
4. Malaria smears, 140.
5. Stools, 142.

The greatest number of stool examinations and malaria smears was done by the 9th Service Command Laboratory. Our laboratory was staffed by trained German technicians.

Physiotherapy procedures totaled 45,492 for the year. German technicians trained in various forms of heat, hydrotherapy, and massage carried on this work and did a very creditable job.

The treatment room was staffed by two German surgical technicians who applied some 11,145 dressings during the year, and took care of a multitude of other things. The only difficulty we had with these men was in making them avoid using a roll of gauze bandage for a practically non-visible laceration. If there was a laceration a quarter-inch long which extended through the skin, they would more than likely use three four-inch rolls of gauze. It seems that a German puts ichthyol on everything he can, and then swathes the part in yards of dressings.

Patients treated in dispensary wards totaled 545, and those hospitalized in a general hospital totaled 276. All the men treated as bed patients in the prisoner of war camp would ordinarily have gone to the station or general hospital, so it can be seen that having facilities for their care within the camp itself greatly reduced the hospital load.

Light duty details have been mentioned. In explanation we wish to say that according to the Geneva Convention a setup such as this must exist. Details are divided into heavy work, full duty, light work, and no duty, and all prisoners brought into the camp are given complete physical examinations with a view toward segregation into these groups. From time to time, due to accident or disease, details have to be changed. In many instances it is very difficult to make up ones mind as to the group in which a man is to be placed. Naturally, most of them desire as light work as possible. In this connection it is interesting to note the decrease in light duty and increase in numbers of men available for full or heavy duty throughout the year. This is all the more important when it is realized that the population of the camp increased throughout the year.

Total on light duty first three months	212
Total on light duty second three months	273
Total on light duty third three months	138
Total on light duty fourth three months	68

During this period the population rose from 3,200 to 4,790.

A dental dispensary was maintained in the main camp. This functioned at first with two American dental officers; then by using a so-called German "civilian dentist" one American officer was relieved. On the whole, teeth were in an extremely bad condition, and dentistry that had been performed by German dentists was far below American standards. The following figures illustrate the volume of work done:

Admissions	4,911
Sittings	17,449
Examinations	3,901
Caries	4,368
Extractions	3,299
Anesthesia	3,276
Postoperative treatment	2,175
Gum treatment	298
Calculus removal	80
Alveolectomy	105
Tooth treatment	513
Dentures adjusted	60
Bridges repaired	22
Crowns	18

CONCLUSIONS

In a review of all patients seen at this German Prisoner of War Camp during the year ending August, 1945, in which the total sick call was 30,934, certain facts are outstanding:

1. There was a large number of cases which resulted in non-effectiveness for work because of bone, joint, and dental pathology. Fractures and sprains resulted from sport and transportation accidents about equally, and the number was high. A very high number of men with advanced caries, and a large group that was edentulous, added considerably to the dental work done. There is a possibility that the cause of fracture and the condition of their teeth may be associated with previous poor diet over a long period of time in Germany.

2. Furunculosis created a problem of rather high non-effectiveness for work of prisoners of war, totaling at times as much as thirteen per cent of all men on sick call. A like group of American soldiers had a total of less than one-half of one per cent. Special treatment including penicillin and vaccine was of no benefit in reducing recurrence.

3. There were so many prisoners with intestinal parasites that much caution had to be used in diagnosis and treatment. Forty per cent of all positive stools showed Endamoeba histolytica.

4. Morbidity was high due to genito-urinary disease. African experiences of dehydration over long

TABULATION OF DATA, 31 AUGUST, 1944—31 AUGUST, 1945

1. Total Sick Call		30,934
2. Fractures:		
Upper extremities	23	
Lower extremities	9	
Skull	3	
Pelvis	2	
3. Malaria		12
Recurrences		17
4. Intestinal Parasites:		
Positive stools		800
E. Histolytica		320
5. Furuncles		545
6. Sprains and strains:		
Knees with effusion		109
Ankles		191
Others		474
7. Kidney diseases		68
Cases hospitalized		55
Albuminuria		22
Hematuria		10
Nephritis		12
Pyelitis		4
Calculus renal		6
8. Mental diseases		11
Total psychoneurotics		9
As a result of persecution		5
Psychosis		2
9. War wounds		134
10. Upper respiratory infections		1,515
11. Ruptured intervertebral disc		3
12. Tuberculosis:		
Pulmonary active	3	
Pulmonary arrested	4	
Genito-urinary	1	8
13. Syphilis		3
14. Peptic ulcer		5
15. Diabetes mellitus		1
16. Jaundice		8
17. Pneumonia		5
18. Pleural effusion		13
19. Deaths:		
Active pulmonary tuberculosis and superimposed pneumonia, Type XVII		1
Strangulation by hanging		1
Coronary occlusion		1
20. Laboratory procedures:		
a. Total gastric analysis		119
b. Total urinalysis		2,015
c. Total blood counts		1,187
d. Total malaria smears		140
e. Total stool examinations done here		142
f. Other laboratory examinations (9th Serv. Cd. Lab.)		2,025
21. Physiotherapy treatments		45,492
22. Dressings		11,145
23. Bed-patients in dispensaries		545
24. Number of light-duty men first three months		212
Number of light-duty men second three months		273
Number of light-duty men third three months		138
Number of light-duty men fourth three months		68
25. Number of cases on sick call first three months		10,352
Number of cases on sick call second three months		9,098
Number of cases on sick call third three months		6,885
Number of cases on sick call fourth three months		4,599
26. Total number of hospitalizations		276
27. Number of cases on quarters for the first three months		5,473
Number of cases on quarters for the second three months		4,307
Number of cases on quarters for the third three months		3,821
Number of cases on quarters for the fourth three months		2,352

periods of time may help explain the number of patients with nephrolithiasis. No adequate explanation is offered for the large number with primary albuminuria and hematuria.

5. Out of a group of nine cases diagnosed "psychoneurotic," five were attributable to persecution by other prisoners.

6. German doctors, as exemplified by a group of six in this camp, showed them to be at a marked disadvantage when compared to American standards.

7. Every effort was made to insure adequate medical care for the German prisoners of war. Certain plans had to be put into effect, however, to reduce malingering and to reduce the effectiveness of German medical officers in trying to cut down the number of prisoners available for work.

8. After more than a year's work with a large number of German men who should represent the most vigorous and healthy group in Germany certain conclusions seem apparent. Although these men appear to be well developed physically and apparently healthy, it seems, on comparing them with American soldiers, that they are actually below standard.

The rigorous Hitler Youth Program which many of them went through seems to have encouraged good muscular development, but little else from a health standpoint. They were encouraged to expose themselves to all sorts of inclement weather without proper clothing. I have seen men in this camp time and time again playing soccer, tennis, et cetera, in nothing but shorts when all of the American personnel wore overcoats.

Naturally, this type of exposure is not conducive to good health. The restriction of diet with a lack of essential foods and vitamins in the pre-war and war years may have had some bearing on the matter. The high incidence of upper respiratory infections, pleural effusion, tuberculosis, genito-urinary disease, fractures, furunculosis, and dental pathology leads to the belief that after all Goebbels was wrong in his assumption of the term "Supermen."

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APRIL, 1946

Editorials

MEDICAL CARE TO INDIANA VETERANS

At the special meeting of the House of Delegates of the Indiana State Medical Association, held on January 27, 1946, it was ordered that some plan for veteran medical care be worked out. The association committee has presented such a plan, which will come up for action at the quarterly meeting of the Council of the Indiana State Medical Association, in Indianapolis, on April fourteenth.

The proposed plan provides some half-dozen "points," and on first reading seems to cover the problem quite well. It provides first that the veteran be given medical care in his home community, in the office of the physician or at the local hospital. However, it will be necessary that a sufficient number of physicians in each county agree to serve in this connection. It distinctly provides that the veteran shall have free choice as to the physician he wishes to consult.

It provides that the association shall set up a board which shall act as referee in all controversial matters; for example, the question of fees to be paid by the Veterans Administration.

The Veterans Administration will have complete charge of such matters as authorizing medical and other services for the veteran, and the checking of the bills, et cetera.

A fee schedule is provided, which to us seems liberal enough under the circumstances, although it must be favorably acted upon by the Council ere it becomes official.

While such medical services are to be arranged for in advance and given official "O.K." by the liaison officer of the Veterans Administration, emergency service is provided for under the proposed plan. We assume that service-connected disabilities are concerned in the present proposed plan. It definitely provides that veterans holding a dishonorable discharge are not eligible for such services.

The proposed fee schedule will be considered by a proper committee in each of the component societies, whose recommendations will be gone over by the committee.

This committee, of which Drs. Charles F. Thompson, of Indianapolis; A. S. Giordano, of South Bend; and W. H. Garner, of New Albany, are members, deserve special credit for the work they have done and the sensible, understandable plan they have submitted. The whole problem of veteran medical care is one of the most important to come before the medical profession—as well as the nation—in our time. It is a *big* problem, one that calls for action by men who are willing to devote considerable time to its solution.

Most of us are familiar with the concepts of General Hawley and know how sincerely he wishes to put this whole project on a fair, equitable basis. It is no longer a political football; it is of too great importance to be regarded lightly. Nor have we seen the crest of the matter; veterans entitled to these services, thousands of them, have not as yet applied for treatment. It is assumed that for twenty years or more there will be an increase in such demands, rather than a decrease.

Indiana Medicine has before it a comprehensive, workable plan; it now is up to us, as individual members, to back the committee and the Veterans Administration, and get going.

LARUE D. CARTER

Indiana Medicine again pauses to pay final homage to one of its illustrious members, a man who not only was known throughout his native state, but who had been accorded the highest honors given to men of his specialty over the entire country.

"Ruie" Carter, as he was best known to his friends, graduated from the Indiana Medical College, now the Indiana University School of Medicine, in 1904, where he later became head of the Department of Neuropsychiatry. For many years he had operated "Norways," the sanatorium

founded by the late Dr. Albert E. Sterne; Doctor Carter was an associate of Doctor Sterne. He was sixty-five years of age at the time of his death.

Only recently, with the organization of the Indiana Council for Mental Health, Governor Gates had appointed Doctor Carter as the head of the Council. In talking with Doctor Carter about the general plan a few months ago, he evinced the highest interest in the program, declaring that with the new hospital building he expected Indiana to take front rank in the matter of the "screening" of mental cases.

In 1916 he entered the Army Medical Corps, serving until 1919. During this service he had attained the rank of colonel. During World War II he served as medical liaison officer, for Indiana, for the Fifth Service Command.

During the war years, at our annual conventions, Doctor Carter was called upon to pay tribute to Indiana physicians in the service, and on each occasion he presented, in his inimitable manner, the feelings of those of us who remained at home.

He had held many offices in medical organizations, including the presidency of the Indianapolis Medical Society. For many years he served that group as a member of the House of Delegates of the Indiana State Medical Association, and in his quiet manner he aided in many of its programs.

Ruie was a good mixer; he made friends readily, and was a man who was sought out by everyone who attended our annual conventions—not to have seen and talked with him at these annual affairs was to have missed one of the high points of the meeting.

In his specialty, neuropsychiatry, he was accorded the highest recognition, both at home and throughout the nation. Hence, when the Council was being organized there was but one man to head it—Dr. Larue D. Carter. Governor Gates frequently expressed himself as being highly interested in the new Council, and the fact that it was headed by the best man available.

Ruie Carter leaves a lot of memories for those who have known him through the years; memories of a man of highest character and highest professional standing; memories of a lovable chap, one with whom we always were glad to associate at the various state medical gatherings. Thus, we add another name to the list of illustrious sons of Hoosier Medicine; men who have served long and well, and who have gone to their last reward.

MACDONALD vs. STATE OF INDIANA

Such is the title of an appeal from the Lake Circuit Court to the Indiana Supreme Court, as noted in the *Northeastern Reporter*, of February 20, 1946. This case is of much interest to the medical profession, particularly those residing in and about Lake County, since it concludes the effort, through many years, to curb the activities of a chap who long has defied the law.

MacDonald came to Gary, several years ago, setting up an office as an optometrist. At one time he had been employed as such at the Chicago Eye, Ear, Nose, and Throat Hospital, where he had an opportunity to observe the routine treatment of these organs. Soon after he came to Gary the local telephone classified section carried the announcement of Dr. William F. MacDonald, as specializing in Eye, Ear, Nose and Throat work, and a sign of similar character bedecked the door leading into his office. We also recall having seen his "professional" card, on which he was listed as an "ophthalmologist."

Mac proved to be a good salesman, and as time went on his practice increased. Somehow or other, in the course of his "educational" career, he had acquired two drugless school diplomas, which he registered with the Indiana State Board of Medical Registration and Examination under the 1927 amendment to the Medical Practice Act. These diplomas, he thought, would stand him in good stead later on in his career. He broadened his practice as time went on, and soon was doing sinus work and all that sort of thing.

The local medical society was observant of what was going on and made sporadic efforts to curb his activities, but with little result. Finally, the state medical board revoked his drugless licenses, but it seems that he carried on just the same. Later on concrete cases were worked up and the entire matter was presented to the local prosecuting attorney. Mac was haled into the local Circuit Court, where, via jury trial, he was found guilty of practicing medicine without a proper license, and the usual fine was assessed.

Mac appealed to the Supreme Court, which upheld the verdict of the lower court, and in so doing made some rulings—these becoming law in Indiana—that will prove of inestimable value.

Judge Richmond wrote the decision, and from it we quote rather liberally. The usual citations were noted, and rulings made thereon. The court found that Mac did have the Eye, Ear, Nose, and Throat sign on his door, and that official receipts for fee payments also bore this legend. The appellant had admitted that he did not have a license to practice medicine, but that he did have one for the practice of optometry. His attorneys complained, in the matter of the revocation of the two drugless licenses, that the appellant had not been notified of these revocations by the local County Clerk, but evidence indicated that he had been notified by the state medical board; hence, the judge overruled the protest of his attorneys in this matter. It seems that when such revocations are made it is the duty of the county clerk to make such a notation upon the margin of the record of such license, but in this case the clerk had not made a notation to the effect that the licenses had been revoked. (To a layman this would seem to be somewhat of a puzzle.) The judge held that it was not necessary that the county clerk

notify Mac that his licenses had been revoked, so that was that.

The court further held that there was no error in the court's instructions as to what constitutes the practice of medicine, nor was there an error in excluding testimony as to whether patients treated by Mac were cured or benefited. The attorneys for the appellant contended that as an optometrist he had the right to do "certain things," in which Judge Richmond did not agree.

In making the appeal to the Supreme Court the appellant's attorneys introduced some novel things: one of their pleas said, "in order to correct vision, it may be necessary to administer medicine to the eye in order to ascertain what the trouble or disease or defect is," but the justice was adamant, refusing to be in accord with any such notion.

Then the appellant's attorneys wailed long and loud because the trial court had refused to permit their defendant to testify as to his training in the Eye, Ear, Nose, and Throat specialty. And here again the hearing judge was adamant; said the court had ruled properly in that matter. It is also to be noted that Mac had on hand some "expert" witnesses, ready to testify as to Mac's skill in his new field, but such testimony was not admitted by the trial judge. The final entry of Judge Richmond reads, "Finding no error, the judgment is affirmed."

So ends this phase of a case that has been a "thorn in the flesh" for Lake County doctors for many years. Just what the astute Mac will do about it remains to be seen. Legally, the matter is closed, since the Supreme Court of the State of Indiana has so ruled—and that is final.

The MacDonald case is by far the most interesting of many similar cases filed in the local courts. The trial was long drawn-out, not a single point being overlooked by his attorneys in order to gain a wee bit of foothold. His chief attorney, a lawyer from Chicago, is said to represent one or more of the drugless groups; hence, made every effort to introduce this and that bit of testimony that might fortify his case even a little.

The opinion of Judge Richmond is a very readable bit of writing; it is exhaustive, and from the standpoint of a layman, we cannot see how any future violator of the Medical Practice Act of Indiana can hope to escape proper punishment. The man who worked up the case spent many months in compiling and sifting the evidence, and when the matter finally was presented to the prosecutor, that worthy remarked, "We seem to have an iron-clad case, let's go!"

APRIL AND VACATION THOUGHTS

With the coming of spring, most of us begin to look over the sporting magazines, seeking new lures for the finny tribe and wondering just when that new outboard motor will be available, and, above all, about new rods to replace those that are getting rather ancient—many of them having been broken.

We went to the Sportsman's Show, in Chicago, the other evening, and interviewed several manufacturers of items needed by the vacationists. We talked with resort owners from this country and from Canada, and in general spent a very pleasant evening.

First, concerning transportation: gas is, of course, freely available, and good tires are no longer much of a problem. Perhaps the old car will not "do" sixty to ninety miles per hour, but it will still get you there and bring you back.

For those who wish to go by train we find that many of the restrictions of past years have been removed. For example, from Chicago to upper Michigan and Wisconsin points Pullmans are now available. And reservations may now be made long in advance; hence, the sit-up-all night program no longer prevails.

But we would urge that immediate reservations be made, both for train service and for your favorite resort. We met several resort operators who are "sold out" for the season; the only chance one has of getting at those places is by signing up for a possible cancellation. On the other hand, several camps that had closed for the duration will again be open, thus providing accommodations for additional hundreds.

The "house boat" idea seems to have gone over big in the last few years. We note that several camps now provide such accommodations, which to us are just about the last word in vacation comfort. The expense is no greater than for other accommodations, and the advantages are many. They are available for four to twenty persons, although our recommendation is for the smaller groups. At Lake of the Woods, Ontario, these boats cover a wide range of fishing grounds, and with the powered canoes one can explore almost unlimited territory.

Outboard motors again are available, even though your name probably will be on the waiting list for a time. If you are thinking of a new motor for this year, better sign up right now. These plants do not require reconversion, since they were running at full capacity and their only present problem is that of material and labor. Prices are no higher than they were before the war.

As is often the case, many Hoosier physicians will prefer to take their vacation at one of Indiana's famous parks, and there is no better choice for those who want to take it easy. But these park hotels and cottages are also limited in number and as to capacity, so it would be well to look after that reservation, too, even though it may be two to three months before you expect to leave.

Hundreds of Indiana physicians have not had a real vacation in four to five years. They have been too much occupied in wartime duties. It is these men that need a vacation most, and we hope that every one of them will be going some place or other in the next few months. Get out your

resort literature, if you have received any this year; and if you have not, look over the vacation-travel section of your Sunday newspaper; read what these resorts have to offer; write for details, and get ready to go.

THE ARMY MEDICAL LIBRARY

Just prior to our entrance in World War II, congressional hearings were being had in the matter of a new building for the Army Medical Library, this body already having appropriated sufficient funds for the drawing of plans for the institution. Of course, with the onset of the war all these plans were held in abeyance, but now an effort is being made again to bring the matter to a head.

Most physicians are not informed as to when this library was first opened; it was 'way back in the time of the second Jackson administration that Surgeon General Lovell conceived the idea of housing medical books, papers, and such material in a government-owned building. This was in the year 1836, and since that time there has been amassed perhaps the greatest collection of medical literature in all the world.

Practically every medical book published is in the listing of the library. It is said that more than 5,500 serial titles are recorded, including more than a million items. Some half million of these are bound volumes.

"The Honorary Consultants" to the Army Medical Library has issued an appeal for assistance in the present promotion, this list comprising seven names known throughout American Medicine: John F. Fulton, of the Yale University School of Medicine; Chauncey D. Leake, of the University of Texas School of Medicine; Harold V. Jones, of the Army Medical Library; Clyde L. Cummer, of the Cleveland Medical Library Association; Wilburt C. Davidson, of the Duke University School of Medicine; Morris Fishbein, of the American Medical Association; and Major General George F. Lull, United States Army, retired, at present Assistant Secretary and General Manager of the American Medical Association. This list reads like a page from *Who's Who in American Medicine.*

The present building dates back to 1887 and is no longer suitable for such an institution. As a matter of fact, much important material has to be stored instead of being immediately available to those who wish to consult some book or paper therein. It is also a matter of interest that during the recent war much of the library material was shipped out of Washington, "just in case," a great part of it being sent to Cleveland.

We are all well aware that a medical library is a first "must" in medical education, as the late Dr. William H. Welch, of Hopkins University, universally accorded as the greatest teacher of pathology in all medical history, remarked: "I have been asked on more than one occasion as to what have been the really great contributions of this country to medical knowledge. I have given the subject some thought, and believe that the following four should be named: (1) the discovery of anesthesia; (2) the discovery of insect transmission of disease; (3) the development of the modern public health laboratory; and (4) the Army Medical Library and its Index-Catalogue. *The Library and its catalogue are the most important of the four.*"

Let's go back into history for a moment, back to 1879, when the then Surgeon General reported some fifty thousand books on the library shelves and recommended that a new building be built at a cost of a quarter million dollars. That is the building being used at present, which is wholly unfit for the purpose and utterly inadequate. Here are stored bits of medical literature, some more than five centuries old, most of which is irreplaceable. That there is need for new housing cannot be denied, and the proposed project should include plans far into the future.

Yet, this will cost a few million dollars, but it will be money well spent; an investment that will pay dividends as long as medicine survives. And we are asking for such an appropriation at a time when Congress has under consideration the matter of loaning several billion dollars to foreign nations, some of which already owe us considerable sums, dating from World War I. The appropriation we are asking for is an investment in America's future; it will pay dividends for ages to come. As we hark back to a favorite topic, "Medical Education," we ask, "Just how shall we improve medical education without a library?" It just cannot be done, and here we have an opportunity to preserve invaluable medical literature as well as add to it as the years go by. If our county and state organizations would take action now, we believe that congress would be in a receptive mood and would grant the appropriation that is to be asked. There are no politics in this, and it is a matter of interest not only to the medical profession of America, but to the entire American people as well.



Editorial Notes

The American Psychiatric Association has given unqualified backing to the program of General Bradley, head of the Veterans Administration. In an announcement sent out by its Committee on Education, the proposed plan of the General to locate all new veterans' hospitals as near the great medical centers as possible meets with the approval of the committee and the association in general. They express the hope that politics will not enter into the matter in any guise, but that the needs of the patients shall be the prime consideration.

In a recent release from the National Society for the Prevention of Blindness it is declared that fifteen per cent of the blindness in this country is caused by syphilis and gonorrhea, at least 34,000 of the 230,000 blind persons in this country having lost their sight through these diseases. A further interesting statement in this release is that 60,000 babies are born with congenital syphilis each year. Many of these develop eye trouble later on, unless treated early in infancy. From an economic standpoint alone, this is an expensive matter, costing the taxpayers millions of dollars annually.

The Medical Society of the State of New York has issued a pamphlet, "His Future is Brighter, Thanks to Medical Research," designed to be an answer to those who would prevent the use of dogs and other animals in laboratory investigations. The pamphlet stresses the work that has been done in bringing about a control of diabetes; the results of blood transfusion, as exemplified in the recent war; the marked decrease in deaths from diphtheria; the control of tetanus, via the antitoxin method, et cetera. Such information is invaluable in combating the cries of the antivivisectionists.

We wonder just what "brand" of therapeutics the younger generation of physicians were taught; it is certain that on occasion they come up with some things we older ones never heard of.

We recently had our biannual siege of "head cold," plus an unusual amount of disturbance from a chronic sinus infection, and had been using the old-time remedies, which formerly seemed to do the trick. It seems that Doctor Jim, about seven years out of school, had different ideas. He came in yesterday, looked me over, then announced, "I'm going to put you on 'bland and blank,'" neither of which I knew anything about. Later in the day he came in with two packages; the prescription price of the pair being $16.95, and told me how to use them, or else. Our Scotch ancestry caused us to wince a bit when we learned the price of the two packages, and if they are not really specific there is going to be a family upheaval about the whole thing.

Well, finally it happened, referring to what took place at the Purdue Field House Saturday evening, March ninth, when two small-town basketball teams, Flora and Culver, met the Goliaths from Lafayette and East Chicago. Long have we hoped that such a thing might happen, and to have the team from our old home, Carroll County—just a hop-step-and-jump from our beloved Wildcat—do the trick, makes it all the more enjoyable. The Flora Badgers, along with Culver, taught the "Big City Fellers" many a new trick. Glory Be!

Those who thought "war gardens" would be generally discontinued this year are now advised that this is not the case. Even though the war is over there is greater need for these "food-basket fillers" than at any time in many years. Citizens are advised that food shortage is more general throughout the world than at any time during the war, and that we must all pitch in and do something about it. One example we have seen quoted concerned canned tomatoes; it is declared that the stock in reserve will be exhausted by July first, whereas in former years at this date the backlog was some ten thousand cases.

Present indications are that by the time this number of THE JOURNAL is published hearings on the Wagner-Murray-Dingell Bill will have begun before the Senate Committee of Education and Labor, chairman of which is Senator Murray, of Montana, co-author of the bill. The hearing was set for March 18, but with Senator Wagner ill, and Senator Murray not in Washington, it is probable that the hearing will be postponed. Our official Washington representative, Dr. Joseph Lawrence, believes that the first witnesses called will be representatives of the government bureaus, many of whom already have evinced a healthy interest in promoting the law.

In a report made by Dr. George M. Brother, who directed a state-wide hospital survey recently, it is stated that Indiana needs something like 4,500 additional hospital beds. This is based on the accepted ratio of good hospital service of four beds per 1,000 population. At present the ratio for Indiana is but 2.7 beds per thousand. According to the report, the larger urban centers are rather well cared for in the matter of available beds, while certain rural areas, notably in the southern part of Indiana, are illy provided for. Indiana now has ninety-one regular general hospitals with twenty-five or more beds, and forty-five smaller general hospitals with a lesser number. In addition, there are eleven state hospitals, counting those at the University Medical Center as one. Already a state-wide problem, this becomes more acute when it is remembered that our present plan is to care for a large number of Veterans Administration cases in our local hospitals. The erection of a rather large number of small county hospitals, properly located, would be of vast benefit in solving the problem of hospital care in Indiana.

The *Fort Wayne News-Gazette*, of February tenth, announced that as of the previous evening there was not a room available in either of the three Fort Wayne hospitals—Methodist, Lutheran, or St. Joseph—some of these already having placed cots in corridors and other such places. It was announced, however, that emergency cases would be cared for somehow. It was said that this is the first time that all three of the hospitals were filled to capacity at the same time.

The annual tax headache has for most of us come and gone, and has left us in a dither as to how we may meet this annual problem with a modicum of ado. The "pay in advance" program is hard for most of us to understand; hence, when the first of the year comes around, and we check up on our income for the previous year, many of us find that we worked much harder than we expected to work, and that our income was accordingly increased. Taxes never have bothered us much, especially the federal and state income variety. If we are making money, we pay; if not, we do not pay. Simple, isn't it? But under the new rule, where we file an estimate for the year to come, and pay our quarterly installment based on that estimate, by the end of the year we feel that that particular obligation has been met. Then along comes our tax consultant who checks over our records, does a bit of figuring, and comes up with the announcement, "You owe ___ hundred dollars, *balance for 1945*." Well, one does not argue about that sort of thing; merely takes his pen in hand and writes the check, all the time feeling that the 1945 taxes had been paid!

Better look over the old garden plot, burn all the trash thereon, get it plowed or spaded, lay in your seed supply, and get going.

Rarely do we recommend a specific variety of vegetable, but this year we have two that are "standouts." First, Bibb lettuce. It should be planted early, for it will not stand the summer sun. Plant it thinly, and later thin it out to about four or five inches. The young plants transplant very well, so do not throw them away when thinning out. Most seedsmen now have this seed, and it is tops. It can be planted late in August for a late crop.

Our second recommendation is the hybrid cucumber, brought out last year by Burpee. A dozen seeds will provide the average family with all they can use for table purposes. In our several decades of gardening we never have found anything that pays better dividends.

While we are at it, we might as well include tomatoes, the universal garden favorite. This year we will use but two varieties, Marglobe and Rutgers. We tried the latter last year and will repeat it again this year. No more bothering with the old-time beefsteak (Ponderosa), nor with any of the new-fangled sort—the two above mentioned will suffice for us. Luck to you!

It is not a generally known fact that in some of our county tuberculosis hospitals regular school classes are being maintained. A notable example is at the Healthwin, in St. Joseph County, where a fully-accredited high school course is carried on; credits therefrom being accepted by every school and college in Indiana. There are numerous advantages in such a system, not the least of which is that the hospital patient, instead of lying in bed doing little or nothing, is enabled to carry on his school work, plus the fact that his mind and time are occupied—a thing much to be desired in the management of all chronic illnesses. An elementary school program for the younger patients is also a part of the educational system. We do not know how many other institutions there are in Indiana which carry on a similar program; we just happened to learn of the Healthwin plan through an article in the *South Bend Tribune*.

A young chap, less than three years out of medical school, recently announced, "I am going into surgery, and am looking for an office." We made some inquiry as to his training for this specialty and were advised that he had had an unusual training; that he had served an internship in a modern hospital with a large surgical service, and that he had had a residency during which time he had "specialized" in surgery, and accordingly felt competent to go out for himself.

We asked him to sit and talk for a bit, wishing to learn more about the "modern" system whereby after three years in hospital work one was able to qualify as a general surgeon. We asked how much bedside experience he had had with sick patients, those under his personal care; how many patients he had seen in their homes; and how much experience he had had with sick children. Without hesitation came the answer, "None!" There you have the picture, all too common, for this young chap is but one of hundreds—we might say, thousands.

We very quietly and also very firmly told this young man that he was making a blunder right at the outset of his medical career; that, although he had seen a lot of surgery and had assisted in many operations, he definitely was not a surgeon and could not be one for some years to come. We said, "You have had no medical experience, no medical background; you never have met patients in their home nor at your office—it just can't be done, don't try it!"

The young man left the office, not at all peturbed; and as he went out, he said, "Glad to have seen you again, but you are all wet!"

We still feel that we were correct in our analysis of his plan. Through the years we have seen and known surgeons, *and surgeons;* we have seen successes and failures, the failures usually being due to a lack of proper background.

Despite the fact that many physicians are being discharged from the Army and Navy, there continues to be a shortage of physicians in the smaller cities and in the rural areas. Dr. C. R. Bird recently pointed out that there are at least forty such communities in Indiana where there is an acute need for more medical care—that is, of permanently-located doctors in those areas. He specified one place, Medora, where in an area of some twenty miles there is but one physician, a man who long since has passed the retirement age.

Like Dr. Bird, we feel that many young medical men are missing a golden opportunity. Life in the smaller communities, as a "country doctor," is no longer a hardship. For the most part there are no long drives; the telephone, the radio, and the daily newspapers all tend to keep the doctor and his family in close contact with the outside world; local markets and trading points are only a short distance away; and even the current movies are available.

Further, in the matter of competence, it has been our observation over a long period of years that the rural physician does about as well as his city brethren, and at the end of the year has more to show for his labor. One thousand two hundred seventy-five Indiana medical men "joined-up" in the early days of the war, placing us well at the top in the matter of such enlistments. Almost a thousand of these entered directly from private practice. Something like seven hundred of them have returned to their former homes, there to again resume practice if they are able to find housing and office space, things that continue to bother a great many of them.

We believe that within a few months this shortage of physicians will have been pretty well taken care of in most sections of the state; a goodly number who perhaps had thought of going to the larger cities will have thought it over and decided that the old-home spot looks pretty good.

Students of social conditions in Indiana, as well as in other states, are amazed—if not appalled—by the figures being released from our courts in the matter of divorces. Just recently the Indianapolis press, as a unit, had much to say concerning the present situation in Marion County, each of the six judges having been interviewed in the matter.

Thousands of such cases have been heard by this group since the first of the year, and it is freely estimated that the increase throughout the remainder of the year will be marked.

Postwar conditions have much to do with the present situation, according to these judges. The return to normal living seems not to be agreeable to many couples. It is our opinion that in many cases the fault may be found in the fact that wives are no longer receiving large industrial pay checks, plus allotments from the Army or Navy; they simply cannot make the necessary readjustment that must follow such changes. The great majority of these folk saved little of their wartime income; hence, find themselves quite restricted just now. As more than one of them have expressed it to us, "We are leading the life of Riley, and to go back to caring for a home, doing the cooking, the laundry, and whatnot, that is out!"

Some of the young men with whom we have talked have declared that they looked forward to coming back and to re-establishing their home life, but they found things changed!

Many other complications of married life enter into the problem, all of which are conducive to a trip to the divorce court unless immediately corrected.

The complaint is too commonly made that it is "too easy" to get a divorce in Indiana, and in many instances it would seem that this complaint is well grounded. Agreement as to "cruel and inhuman treatment" on the part of one or the other seems to be commonly met, one of the parties agreeing not to contest or to appear in court when the case is heard.

Our socially-minded groups have a huge task ahead of them, if they care to attack it. Even the judges admit that they are utterly confounded by the piling up of these suits in their courts.

WAR IS NEVER OVER FOR THE RED CROSS

The Red Cross battle goes on for your men overseas, your men in hospitals, your veterans, and for war victims.

For four long years the American people put everything they had into winning a global war, winning a war that bears no comparison in history for destruction and horror. Millions of men gave their lives fighting for world freedom, dying on far-flung battlefields. So that their efforts may not have been in vain, the American people must work as hard for peace as they did for war. Through your Red Cross you may serve as they did for war.

President's Page

We are now passing from the drab winter days into the most beautiful season of the year, into what has been designated as spring. Men and women have written tomes praising the return of nature into a full dress rehearsal of all her beautiful array, bringing to mankind a realization that no matter how dark and drab may have been the days, weeks, and months that have passed, we can now look forward to the restful and healthful warmth of sunshine and a personal inner feeling that all is well, and that we want to live and be of the greatest benefit to mankind that our limited capacity will permit. But as the bright spring day begins, full of promise, happiness being the predominating feeling, and as we go about our daily tasks with a light heart, suddenly dark clouds loom before us with threatening storms in the offing, and our mood changes to one of fear and despair. This is merely an example of the world today, and is very applicable to the fast changes that are taking place in almost every walk of life, especially those designated as state craft industry and medicine. What the outcome will be no one knows, but the ship of state must be kept on an even keel. Industry and labor must agree: one cannot exist without the other, and arbitration and the ability to recognize the basic principle of the rights of free enterprise must prevail.

Medicine as we know it is on trial for its existence. We are in the presence of clouds of discord from without and within, and as these clouds gather some may very easily develop into a devastating storm which will wipe from the world the freedom of the healing art, through the holocaust of bureaucratic medicine, controlled by cheap and scheming politicians who abet their theories under the guise of "improper medical care for the underprivileged or low income groups of our citizens."

I believe that we all agree that in these groups we detect a ghost-like appearance of greed and selfishness, which is contrary to the concepts of true democracy, and which we as individuals and as a nation have held as our ideal—the highway to the fundamental goal of the fellowship of man.

I think that I can voice the sentiments of all the members in the state organization, that the medical and surgical care of the returning veterans will receive positive, concerted action provided the members are given an opportunity to do so. We must not let it be said or even thought that we would shirk our duty, but unfortunately if the system of employing doctors by the Veterans Administration comes under certain restrictions, we fear that a number of good men would not be available. The least we can do is to assist in every way possible in making the Veterans Administration a more efficient and workable organization, aiming to give the best care to our unfortunate veteran. We must keep in mind that the veteran always comes first, and not some one individual or group of individuals who from selfishness see an opportunity to introduce a caste system—not in so many words, but by action that might lead to such a system. This must not happen.

We admit that this whole program is revolutionary; in fact, this is a test case for medicine. We urge that all doctors be ethical and avoid hazards, such as making unnecessary calls, bill padding, et cetera, for our foes are watching every move that we make and could easily sway public opinion. As a final plea, let us keep medicine free and cooperative!

J. E. Farrell

CANCER CONTROL PROGRESS

SUSA P. MOORE*

INDIANAPOLIS

The cumulative efforts of national organizations, since early beginning in 1913, to achieve a comprehensive attack against cancer have resulted chiefly in establishing the premise that to improve cancer services is to improve the entire gamut of medical service, particularly in directions of medical teamwork. It is conceded that even the most remote practitioner working alone in rural areas is entitled to have at his command for each and every potential cancer patient the fullest range of consultative aid and physical investigation.

Another result has been to build up practically incomprehensible masses of scientific data which without correlation and interpretation could serve neither the cancer patient nor chart the course for effective continuation in research. Even such well-organized and highly-subsidized groups as the British Cancer Campaign have lately been brought to attention by public questionings: Why cancer control movements at all? What are the tangible results to date? Where do we go from here? What is the ante?

The American national society has never issued such a self-searching scientific report as the 1945 statement at hand, summarizing twenty-two years of cancer control activities in Great Britain. The British net result this year has been to make available everywhere regional cancer consultation services. Free clinics: Switzerland has had universal, state-aided cancer clinics for quite some time.

The United States also in every state at given points provides fully-equipped and competent investigative and treatment centers, but these are pitifully inadequate because of population dispersion and because of their widely variant distribution. Nevertheless, it is the United States which shows material statistical improvement—improvement which appears among women in the most susceptible age groups. Earlier treatment generally is being instituted; hence, these improved results should increase correspondingly.

It is to be noted in passing that the improvements appear precisely within the group which during recent years has been subjected to cancer prevention education on the part of the Indiana Cancer Society, Inc. Also, it represents precisely the intelligently cooperative people who can and do become compliant and responsible subjects of progressive medical treatment.

Two announcements of major progress are appropriate concerning organization for control of cancer in the United States. The rather loosely-organized American Society for the Control of Cancer, which found vague and intermittent vocal expression through the Women's Field Army in its state and county units, has been reconstituted as the American Cancer Society. It has been streamlined functionally. Its scientific research unit has become an integrated part of the medical division of the National Research Council. Its service section makes the establishment of centers a major objective, supported by auxiliary services. Its educational division will include fellowships, seminars for physicians, along with abundant lectures and literature for laymen.

National pronouncements state that hereafter American Cancer Society administration shall be democratic through state-by-state representation on business and scientific boards. The society has always stipulated the closest possible relationships with the state and national medical associations. No local project sponsored by the society is set up except as fully approved by medical association members, and executive boards of all local units carry medical members in key positions.

No cancer center is sponsored or maintained except on the basis of minimum standard requirements of the American College of Surgeons. So little is generally known of the extent of these minimum requirements and the reasons back of basic standards that personally we have thought it might be profitable to feature the American College of Surgeons' standards alone in our publicity, rather than laboriously, with our present educational facilities, attempt any really comprehensive public education concerning cancer as a disease and the individual art of dodging it. By that means the public would at least learn that certified institutions and certified specialists are available to them, and that the price of certified and dependable service is less on the open market than the cost of quackery.

The Indiana State Medical Association has been exceptionally ready to aid and abet the Indiana Cancer Society. The chairmen of the successive committees on the control of cancer could be eulogized by name for their special guidance of the Indiana Society through the increasingly complex and difficult administrative matters that have confronted us. Our present executive vice-president, Mrs. Ronald M. Hazen, has seen the Indiana Cancer Society through a crescendo period from $3,500 over-all budgets to the 1946 goal of $282,000 for the state.

The campaign itself has become a major undertaking. This year, at least, it requires separate engineering apart from strict organization work, but it carries through on education. William H. Ball, of Muncie, as state campaign chairman with appropriate subcommittees, will enlist the Chamber of Commerce men and industrialists as aids

* Chairman of Public Relations, Indiana Cancer Society.

in a campaign which will enlighten every person in the state on our programs and objectives. It will give every person abundant opportunity to aid this urgent cause.

Indiana's organizational situation has been greatly strengthened with respect to cancer control. Our purpose as a non-profit group wholly devoted to scientific, humanitarian, educational and service activities in this special field are fully set forth in a newly-granted charter to the Indiana Cancer Society, Inc. William H. Ball, of Muncie, is president; Mrs. Ronald M. Hazen, of Indianapolis, is executive vice-president; Harry V. Wade, of Indianapolis, is treasurer; and Mrs. Katherine Fields, of Plainfield, is executive secretary.

Under the new organization the county becomes the key administrative unit. District chairmen constitute the nucleus of the board. Leading scientists and medical men are included on the personnel of the board. The largest single project now before the organization is an Indiana handbook on cancer being developed in panel discussions in which leading scientists and educators take part. Its classroom adaptations have received official sanction. At present our educational program will present specific Indiana issues instead of broad generalizations.

This year we are facing an informed public within our state and asking them to find an added $282,000 for our cause. We lag behind other states in approved diagnostic services, more especially as to their distribution; and as yet we have found no answer to what has become a highly-insistent public demand for cancer centers—centers permitted to handle pay patients as adequately as we now service the indigent patient. Surely some type of collaborative medical effort can be found to meet this need. In a last analysis one recognizes that an aroused public manages somehow to get what it wants. Shall not the will to serve, the willingness to cooperate, the urge to give progressive medical science legitimate expression in this field come forward to develop the type of self-contained treatment and diagnostic center the Indiana Cancer Control Program seems to require?

PUBLIC HEALTH NURSING

LUCILLE WALL, R.N.
INDIANAPOLIS

"All hands to health!" The National Organization for Public Health Nursing has designated April 7-13 as "Know Your Public Health Nurse Week." The purpose of the "week" will be to acquaint the public with the role played by the public health nurse in community life—in the teaching of maternal and child care, prevention of disease, control of epidemics, early detection of remediable defects, and the teaching of good health habits to school children and adults.

Current proposals concerning more effective preventive health programs and better facilities for care during illness for everyone throughout the country make the services of the public health nurse much more urgent than ever before. In order to carry on an effective generalized public health nursing program, the Committee on Administrative Practice of the American Public Health Association has set up the minimum standard of one nurse to 5,000 population. A ratio of one nurse to 5,000 population precludes bedside nursing and special programs for the care of the crippled. A ratio of one to 2,500 is needed if bedside care and special programs are to be developed.

On the basis of these standards, the need for public health nurses here in Indiana is obvious. In 1942, the 286 public health nurses, of whom more than 10 per cent were part-time workers, represented a provision of only one nurse to approximately 12,000 population, a shortage of well over 50 per cent compared with the ratio recommended by the committee. Since 1942 the demand for public health nurses has continued to increase. Indiana needs approximately 685 public health nurses in order to meet adequately the generalized public health nursing needs of Indiana's three and one-half million citizens.

Opportunities for public health nurses are rapidly increasing. Positions with official and voluntary agencies in both urban and rural communities are available. Industries and schools are interested in employing nurses with public health experience. The trained public health nurse who enjoys formal teaching has opportunities for teaching public health in schools of nursing.

Additional preparation for the professional graduate nurse includes a post-graduate program of study in public health nursing, which may be taken while on the job during short leaves of absence. Since a baccalaureate degree is increasingly necessary, many colleges now offer a five-year course in nursing, leading to a B.S. degree. At least two universities offer basic nursing programs planned for the college graduate.

The growing need for public health nurses, the expanding opportunities within the nursing profession, and the growing realization of the social value of the nurse's contribution to humanity indicate some of the satisfaction to be derived from a career of nursing. The nurse has given much to society; the future will give more to the nurse.

For information concerning programs planned for "Know Your Public Health Nurse Week," or for information related to public health nursing in general, write to the Division of Public Health Nursing, Indiana State Board of Health, 1098 West Michigan Street, Indianapolis 7, Indiana.

THE COUNTY MEDICAL SOCIETY IN THE PRESENT CRISIS*

M. L. MEADORS †

FLORENCE, SOUTH CAROLINA

In a recent issue of *The Index*, quarterly publication of the New York Trust Company, it was stated that during the year 1944 more than $4,000,000,000 was expended in connection with medical care in the United States. "Medicine," the article continued, on the basis of this figure, "has become big business." Big business is the order of the day. It dominates industry of all types, manufacturing, sales, amusements, and business generally, and now the term is applied to one of the most honored and dignified professions.

It is not strange, therefore, that we have come to think of the activities of the medical profession as a unit, principally in terms of its national organization, aided by and perhaps sometimes working through the component state associations. We are prone to consider first, or only, the ability of the American Medical Association, as such, to deal with projected movements in Congress, and there has been a strong tendency to rely entirely upon the Board of Trustees and others in control of the management of the national organization, to form and direct generally the policies of the profession and carry them into effect.

But the success of any big business lies in the extent to which its directors, executives, and managers are able to stimulate, utilize, and correlate the activities of its smaller units, its subsidiary corporations, and branch plants. There may be stages in the development of an industry or organization when it may accomplish its objective by reason of the fact that it is able, through its very size, to overawe its opponents and freeze them into a state of inactivity or ineffectiveness. If that were ever true of the medical profession, which I seriously doubt, it is no longer so.

In this growth in importance and financial extent of the practice of medicine, to the point where the sum of $4,000,000,000 is invested therein by the people of the United States in one year, with its intricate organization and its national prestige, there possibly has been a tendency to overlook the most important element in the structure of the entire organization. The importance of the county medical society can scarcely be exaggerated. These units, collectively, form the broad base which supports the entire edifice. As evidence of the soundness of the principle of county unit organization, consider the two great political parties. Neither of them in its palmiest days would consider entering upon a national compaign without perfecting and devoting ample time, attention, and money to the local organization of each county in every state where the parties maintain any activity at all. You may be sure that a system which is maintained and made use of time and time again by practical politicians has long since proved its value.

Yet, the county medical society, in some parts of the country at least, has been relegated within recent years to the position of a small social group or scientific essay society. Except in the larger centers of population the medical meetings are attended by a mere handful, and the program is devoted to the reading and discussion of papers on some phase of medical practice. Of course, that is fine provided the attendance can be built or kept up to such a level that the majority of the physicians in the area involved will have the benefit of the scientific discussions. But here is one more illustration of how the doctors in their zeal for scientific perfection, in the interest of their patients, overlook the economics of the practice. For in failing to devote a part of the time and activity of the county society to the consideration of the economic problems with which it is now faced is to overlook the finest single channel for constructive action that is open to the medical profession.

The importance of the county society in this respect results from two factors, as you will readily recognize: First, the society furnishes the most direct, ready personal contact among the doctors themselves and between the doctors and their friends among the laymen. Through this organization, more than through any other in the entire profession, it is possible for the doctors to reach each other, and it is also possible for the physicians to reach those outside the profession with whom they would like to come in contact. In brief, the county society is closest to the people. Therefore, and this is the second factor, it is closest to the lawmakers, whether they be members of the city council, the board of county commissioners, the state legislature, or congress. Every member of congress lives within the geographical area of some county medical society. Within that area, which constitutes his legal residence and wherein his home and closest associates are located, is the place where his principal interests lie, and where his ear is most acutely attuned to the demands of the people. In nearly every case, if not actually in all, some of the doctors themselves are numbered among the lawmakers' closest friends and associates. Where that is or is not the case there are, almost without exception, in every county throughout the United States people outside the profession who are mutual friends and admirers of the doctors and the legislators.

With the growing realization, which is clearly evident in the activities of the American Medical

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Association and the various councils through which it operates, of the importance of cultivating public relations, the importance of the county medical society as a medium for launching and advancing such a program must not be overlooked.

One of the most difficult obstacles in the way of successful public relations by the medical profession is the lack of interest and indifference by the doctors themselves toward the economic phase of their work. It is primarily a problem of education. We like to think that the tendency on the part of large segments of the population to believe that state medicine is the answer to all of their difficulties is due to a lack of education and to a weakness of character which permits them to be misled by smooth-tongued politicians and demagogues against their own interests. It is undoubtedly true that the public needs to be educated, but that is not all. Before substantial headway can be made toward education of the public, there must be education of the doctors. Education to a realization of the fact that medical practice and medical care, as it now exists, is not perfect, and that there are many people who lack adequate care for themselves and for their families; many, in reality, for whom it is practically unobtainable. It does no good for the physicians to adopt the attitude that the individual without proper medical care is in that situation solely through his own inability to plan and finance his planning. The profession would be listened to with a far more sympathetic ear by the public at large if, when advancing the argument for its position, it would admit the evident and not seek to deny the fact that many improvements and certain changes are essential for the physical well-being of many members of the public, and for the improvement of the health of the nation as a whole.

The members of the profession, themselves, need to be educated again to the fact that unless certain changes are made voluntarily and quickly those changes will be made for them by the government. I do not mean to say that the changes which are actually needed or the real improvements which can be attained are the same changes or the same improvements which would be realized or effected under a system of government control. In all probability the contrary will be true, but the fact remains that some government program will be tried, and will be tried soon unless a genuine, positive and far-reaching effort is made by the profession itself, and an essential step in the education of many members of the profession is that which would bring to them a realization of the urgency of their need for positive, constructive action.

There has been the general tendency, too often in the past, to adopt an attitude of carping criticism toward every thought suggested and every movement attempted toward any change by reformers within the government, and to totally ignore such efforts on the part of those outside government circles, and whose activities are therefore ineffective. The time has come when the profession can no longer afford to be indifferent or adopt a "holier than thou" attitude in regard to those outside its ranks who would attempt to change the system of medical care and regulate the form of medical practice.

Comparatively little has been done by the profession along the line of directing or shaping the form of legislation in regard to these matters. The answer to that statement, of course, is that the profession has not been given the opportunity to take an active part, but is it not true that, at least in a large measure, the reason why the opportunity has not been extended is that the legislators and those in the executive branch of the government who are concerned with the matter realize in advance the critical and indifferent attitude of the profession, the feeling by the physicians and their organization that in attempting to regulate such things the laymen are trespassing upon hallowed ground, sacred to the profession itself, and that no cooperation therefore could be expected from the latter? There should, I think, be further and rapid development of professional thought along these lines, and in this sense the physicians themselves need further education.

With the position enjoyed by the profession throughout its history in this country, and with the confidence inspired in the public by the conduct and high character of its members, the potential effect of its influence when thoroughly aroused and active is almost unlimited. If a willingness to sit down around the table with the theorists, the idealists, and the reformers, and to reason with them and attempt to discuss the problems on the basis of "equals" could be clearly established, the medical profession could do much to prevent the threatened drastic change and to direct the course of the changes which are made and the future economic development of medical care throughout the nation. The extent of the success of the medical profession in the present crisis depends upon a candid realization of the problems; the cultivation of habits of progressive, tolerant thought; a complete departure from the ultraconservative attitude which has been held by many in the past; a willingness to make changes which are clearly in the public interest; and a spirit of cooperation with others, although they be government officials and political figures, in an effort to work out the solution of the problems which lie before us. In bringing about the education of the physicians along these lines and in achieving the proper attitude the county society is the very point of beginning. That is the first and possibly the most vital purpose it may serve. But it can and should assist actively in the solution of all the problems before us; first, by devoting ample time regularly at its meetings to a consideration of the economic phase of medical practice; and, second, by participating actively in the projects of local or state agencies which are concerned in any way with preserving or improving the general health and medical care of the people.

I have no desire to discuss mere theories, but both

of these things can be carried out in a very practical manner. The time allotted for the purpose at the meeting might be devoted to a consideration of a number of subjects. First in importance would be the health needs of the community from which the membership of the society is drawn. This, at least, will provide an ever-present subject of discussion, for despite our claims, justified as many of them are, health needs, like the poor, are always with us, and there is always room for their improvement.

Very often the tendency in all of us is to overlook the needs around our doorstep while attempting to correct the wrongs beyond our reach. Local health needs of the medically indigent, et cetera, can be better cared for by the members of the county society and through the medium of the reforms which that society can bring about than by any other means. An active, energetic interest in conditions which require improvement would go a long way toward impressing local citizens with the profession's sincere interest in the people with whose medical security it is charged. In this connection I think that it is feasible for a county society to attempt to collect and maintain records on the incidence of disease and to classify the different types most prevalent in the community, to conduct some sort of investigation on its own into possible sources of infection, to study the methods of treatment that are being used, and to advise the municipal or county authorities of any change which a majority of the members of the society believe to be in order. Again, it has always seemed to me that there should be a more direct connection between the county medical society and the department of public health. Before I became associated in any way with the medical profession, the terms were almost synonymous to me. For a long time it was hard for me to distinguish, in my thinking, between the activities of the local medical society, when these were publicized, and the official action of the public health department. Since my connection with the South Carolina Medical Association I have come to realize the complete extent of my ignorance. How little there is, in most communities, in common between the medical society and the local unit of the health department! That is not by any means always, nor in most cases, the fault of the medical society, but it is, nevertheless, a situation which should not exist. All the scientific information and knowledge of the doctors in the community should be available to the public health service or to the county and city departments of health, and the latter should be encouraged to make use of them. It is most unfortunate for the profession, and for the public health service, if the people generally obtain the impression that any degree of antagonism exists between the two groups.

One of the principal objections and one of the main arguments being used by the profession against the Wagner-Murray-Dingell bills is that they would centralize authority in Washington. We maintain that communities differ in their needs and requirements, and in the methods best adapted for use in each community. We contend that the community itself, the city, the county, or at the very greatest, the state, should be the unit of authority and control in matters pertaining to medical care. But what have we actually done about it? What has the medical profession proposed in lieu of the threatened centralization of authority in Washington? What has it suggested to effectuate and implement its proposed policy of local control and management of means for improving the distribution and quality of medical care? The time has just about passed when action by government can be forestalled by simply talking of other means. The hour is here when the other means must be brought forth and put into action, for the government itself is now ready to act. The county society should furnish leadership in the thinking and the action whereby medical care, according to principles of private practice and choice of physician by patient on a fee-for-service basis, can be extended to every individual and family in the community which needs medical care. And a part of the time of each meeting of the county society might well be devoted to a discussion of this very thing.

Only this week an article appeared in *The Journal of the American Medical Association*, with a suggestion of the sort of thing to which I refer. In the scientific paper on "Trichinosis," which appeared in the issue of December twenty-ninth, the author discussed the means of controlling the disease and recommended, as one of the most effective, the enforcement of strict requirements with regard to the processing of pork. "The initiative for such a method of control," he said, "appears from past indications to rest primarily on physicians and public health authorities." I am sure that numerous other instances would present themselves from time to time to an alive and wide-awake county society interested in serving the needs of the community, and, through it, those of the people everywhere.

There are projects in every state, in every community, concerned in one way or another, directly or indirectly, with the health of the people, and the society can profit greatly if it will give material assistance by identifying itself and becoming actively connected with such projects as are worthy. There is nothing in life in which people are more interested than the preservation of their personal health, unless it would be the acquisition of money. One of the chief reasons for the current hue and cry for state medicine is that certain organizations and pressure groups have succeeded in creating an impression in the minds of many people that the health of a vast number of individuals is being neglected because of the determination of another group, the doctors, to give their services only in return for large fees. We on the inside know how little truth there is in such a charge, but we must realize also, if we are practical, how easy it is to get across such an idea in the minds of many people.

The public is interested in the welfare of the medical profession and sympathetic with it only

to the extent, and so long as the public is convinced, that the profession is interested in the welfare and health of the public. The doctor has been looked upon by many people in the past with the same regard and affection as a member of the family. By the same token, the doctor is expected to have a personal interest in the welfare of his patient. The secret of his appeal and the confidence of his patients in the family practitioner was his patent interest in his patients, his willingness to sacrifice his own comfort and well-being to serve those who needed him, when they needed him, and usually his apparent indifference as to the payment of fees.

With the increase of specialization, office practice and office hours, much of the personal touch between the physician and patient has been lost. The practice has come to appear, to many people, more like a business than a profession, and the doctor is regarded more in the light of a business advisor, a real estate broker, an insurance representative, or even a lawyer. This is especially true in the larger centers of population, and there the clamor for complete medical care under government control is loudest. While actually the need is greatest in the rural areas, it is in these areas where the greatest measure of confidence is still maintained in the established methods of private practice. The right of the physician to specialize, to confine his activities to office practice, and to limit and specify the hours during the day when he will be available to patients certainly cannot be denied, but he must be resigned to the loss of the enjoyment of a certain measure of the former attitude of implicit faith and sympathy from his patients in exchange for the increased convenience and income derived from the new mode of operation. The effect of the change can be somewhat offset by a real, genuine interest in matters which pertain to the health of the people, aside from the service for which they are paying, and by the demonstration of that interest by taking part in the activities which are designed to increase and improve the standards and availability of medical care. I realize fully, of course, that most doctors have not the time for extensive activities of this kind; that if they discharge their duty to the people who need and are paying for their services their time will be fully occupied. But that is where the county society, as an organization, comes in. If all members participate the burden on each will be light, and, if necessary, a layman should be employed to administer and coordinate the work.

To illustrate, I can give you two instances of such activities recently engaged in by the profession in South Carolina.

The first, no doubt, is similar to what has been done in this and the majority of other states. A committee was appointed to investigate and advise medical officers returning from the armed services on possible available locations for practice. Through the Procurement and Assignment Service the name of each returning physician is obtained, together with an indication as to whether he expects to return to his former location, and the type of practice in which he wants to engage. On the other side, one member of each county society was selected by the central committee, as its local contact, and was asked to consider the situation in his county, to discuss the matter with other physicians, and, on a basis of these discussions and his own opinion, to inform the committee where vacancies would likely be revealed, and the type of physician—whether general practitioner or specialist—which would be needed. These reports are channeled through our office, and the information placed in the hands of the committee, which is enabled thereby to select from the list of returning officers the men with the qualifications needed in any particular locality, and to recommend him to the physicians in that community. In this way the chances of a returning officer locating in a community already crowded or where his type of services is not particularly needed will be minimized; and, it is hoped, and I believe will prove true, that communities now suffering from the absence of doctors may be supplied with men of the proper qualifications and background, whereby the problem of distribution of medical care will be at least partially solved. You will note that in this plan the emphasis is squarely on the local doctor, a member of the county society, the man on the ground who from his own experience and knowledge and from the consensus of his colleagues can report the actual needs to the central committee.

The other incident to which I refer is connected with medical education, certainly one of the most important long-range projects with which the profession is concerned today. The Medical College of South Carolina has a splendid background. Its traditions are highly respected by the profession and public alike. But it is small. Its facilities are greatly limited. It has not developed in proportion to the expansion of the needs of medical education. At least this was the thought of the faculty and the board of trustees of the institution, and as a result they formulated a plan for expansion of the college, requiring an investment of about $3,000,000; and the plan of expansion and financing was presented to the South Carolina legislature at its 1945 session by the trustees. After strenuous effort and a stormy experience through the length of almost the entire session the bill failed to pass. Sometime later the matter was presented to the state medical association with a call for its assistance in obtaining the necessary legislation. The state organization was unwilling to accept the plan and to give it endorsement and approval without thorough inquiry and investigation, and a committee of seventeen men was appointed, consisting of one from each of the fourteen judicial circuits in the state, the president, the secretary, and director of Public Relations, ex officio, to investigate fully the existing facilities, the need for expansion, the plan proposed by the faculty and board of trustees, and the suggested financial requirements. That committee held four lengthy meetings within the past two months and considered the matter from every angle. They

visited the college and carefully inspected each department, noting the equipment of the present plant and its facilities as well as those of the hospital furnishing the training ground for the students. They heard members of the faculty, representatives of legislative delegations, and others, and finally as a result of these activities arrived at the conclusion that the plan which had been presented was proper and that it deserved the endorsement of the medical profession in South Carolina as a whole. In a called meeting of the House of Delegates, on January third, the report of this committee, and its recommendations, were presented and enthusiastically adopted by the House of Delegates.

One of the recommendations thus adopted was that the committee be expanded from seventeen to forty-nine, so as to include one member from each of the forty-six counties in the state, in addition to the three officers already on the committee. This expanded group will act as a special legislative committee through which the weight of organized medicine in South Carolina will be thrown behind the project, and the probability of passage of the measure at the next session of the General Assembly will be greatly increased. Here again we see the plan of working through the representatives of each county society.

And this leads me to the consideration of another very important angle of the work of the county society. It is by far the most effective medium for reaching the lawmakers and for influencing, in a proper manner, legislative thought and action. There is no doubt in my mind, and the statement is based on both information and personal experience, that all of the lobbying that can be done by the legislative committee of the state organization, all of the publicity and other means which may be employed, are far less effective than personal contact with the members of the legislature by his constituents in his home community. These are the people who maintain him in office. They are the ones he represents, whose interests should be paramount in his consideration. Unquestionably, the doctors in any community, through their personal and professional connections, would be some of the most desirable supporters a legislator could have or seek. A personal interview with the representative, preferably in his home town during a recess of the legislative session, will do more toward winning his support of legislation in which the physicians are interested than almost any other means that could be employed. The county society will always include a sufficient number of diversified talents and personalities to furnish at least a few who are in a position to make sufficient personal contacts in a manner which is inoffensive and, on the other hand, highly acceptable to and desired by the legislator.

Finally, we do not expect to light a lamp and hide it under a bushel. Any or all of these activities which might be undertaken—with the possible exception of the last one mentioned — should be brought clearly to the attention of the public. Let the people know of the interest and the activity of the medical profession, not only in the things which are purely in the private interest of its members and which will serve to increase their income or scientific knowledge, but in those things which have to do with the best interests—the health and the availability of medical care to the people generally. Obviously, the accepted mediums are the press and radio. In addition, numerous other opportunities will be presented from time to time. They are all about us if we will only notice and seize them. For example, opportunities to address various organizations and groups, such as the service clubs, welfare organizations, and business and professional groups, who should be and generally are interested in the long-range trend of development of thought and economic progress. Again, the county society is the unit, the only logical unit, through which many of these things can be arranged, and an alert organization can find the opportunity as often as would be desirable, for some member of the profession, the executive secretary or the officer in charge of public relations, to speak to such a group and to make sure that sufficient publicity is given to his remarks in the local press. Keep your activities before the public—bring the issue out in the open!

Little criticism will be heard from your friends among the laymen, but do not make the mistake of thinking that because you do not hear the criticism, it does not exist. As a layman, friendly to and connected with the medical profession in my state, I know whereof I speak. One of the advantages in having someone outside the profession associated in this capacity is the fact that people will express their views and criticisms more freely to him than they would to some doctors upon whom they might at any time find it necessary to call.

It is an interesting fact, and a surprising one, that some of the most ardent supporters of our capitalistic form of economics, some of those who are the most apprehensive about the danger of socialism and who would for personal reasons abhor such a change, are still of the opinion that government provision for medical care, at least to some extent, is necessary and highly desirable. I do not know whether you have come in contact with that paradoxical point of view, but I have been impressed with it on more than one occasion where I live. They almost seem to take the attitude that business and industry should remain on a capitalistic basis, but that medicine should be administered along socialistic lines. The argument is heard that the public schools are successfully operated by the government, and tax-supported, and that the members of the teaching profession are government employees. Why, then, should not the same be true of the medical profession? And this, I say, is the argument from people in the strata of society in which you and the other doctors of the nation move and have your contacts.

A short time ago I was requested to read a paper on "Socialized Medicine" before a club in my own

home town, composed of about a dozen select men who had organized themselves for the purpose of considering, for their own edification and enjoyment, economic and political problems of the day. The group was composed of men, without exception, in good—some of them in excellent—financial circumstances. They were men of the professions and the heads of business. The paper provoked spirited discussion, and to my surprise the great weight of opinion was to the effect that some government program for the administration and distribution of medical care is highly desirable; that the doctors need controlling; and that hospitals should not be tax-free institutions—for the simple reason that in the hospitals doctors sometimes earn large fees. Here is a situation which I do not believe is generally realized by the members of the medical profession themselves, and it illustrates what has already been said of the advantage in having a layman connected with your organization who can rub elbows with other laymen, to whom their opinions can be expressed without fear of creating enmity or hurting the feelings of the doctors themselves, who generally are personally highly-esteemed, and I am satisfied that the point of view is not a provincial one confined only to my community. I have read enough and heard enough to be convinced that it is fairly representative of the attitude of individuals outside the profession all over the country.

Prepare to meet the criticism, the arguments in favor of regimentation, and the reforms contrary to the best interest of the profession by discussing them publicly. Of course, you will not always convince your opponents. You probably will not do so in the majority of cases. But at least you will raise questions in their minds. You will convince the public of the sincerity and good intentions of the profession, and no doubt you will provoke the expression of feelings and arguments from the other side, which will enable you more effectively to meet the issue.

Information such as I have referred to, as to the activities, the interest of the profession, and medical care for and the health of the public generally, I can assure you is far more effective than erudite or vindictive articles and speeches criticising and calumniating legislators, congressmen, the President, and all those connected with politics or pressure groups generally or, on the other hand, devoted to extolling the unlimited virtues of members of the profession and lamenting the passage of the good old days of the horse-and-buggy doctor.

I think that the national organization has now realized fully, if it had not done so formerly, the necessity of a constructive attitude. The point at which the most effective constructive attitude and action should originate, and at which its force can be applied with the most telling effect, is at the level of the county organization and through its members as individuals. Make no mistake about it, the practice of medicine, medical care, although it may have become big business from the standpoint of the financial consideration involved, is still and will always remain, as long as it serves the purpose for which it is intended, a purely personal, local matter, the finest conception of which is represented by the personal relationship between physician and patient, not simply in the professional capacity, but in the interest and personal contact of daily living.

VETERANS ADMINISTRATION NEEDS PHYSICIANS

The rapid and steady increase of patient loads have created a critical problem in the staffing of the Veterans Administration Hospitals. Thousands of World War II veterans are streaming to Veterans Administration Hospitals every month and are bringing with them all kinds of new and complicated diseases and injuries resulting from global warfare.

To alter these critical conditions Major General Paul R. Hawley, formerly chief surgeon of the European Theatre of Operations and now chief of the Veterans Administration Department of Medicine and Surgery, has instituted a program to secure the finest in medical and nursing personnel to care for veterans.

The Veterans Administration Hospital in Marion, Indiana, is now facing a critical shortage in its medical and nursing personnel. The Marion Veterans Administration Hospital is in dire need of nineteen physicians, twenty-three nurses, and one bacteriologist.

The Veterans Administration medical officers can earn up to $8,750.00 a year, with lowest grade at $3,640.00. Overtime is paid to all grades for more than forty hours weekly. Promotions for qualified personnel are regular—at least once a year. Vacations are with pay—twenty-six days annual leave and fifteen days sick leave every year. Quarters and subsistence, if supplied, are at a minimum rate. Specialists are needed in all medical branches.

The Veterans Administration affords invaluable clinical experience and offers graduate study and professional advancement at government expense.

In brief, the Veterans Administration offers doctors serving in veterans' hospitals the largest net income in proportion to salary that is possible in private practice—regular hours, retirement benefits, and clinical and research opportunities comparable with the best.

For more information, contact Colonel H. H. Botts, manager of the Veterans Hospital, Marion, Indiana; and for the Indianapolis District, write to Colonel M. L. McClung, Regional Medical Director, Veterans Administration, Indianapolis, 44, Indiana.

OUR OWN INSURANCE COMPANY

(Mutual Medical Care, Inc.)

Walter U. Kennedy, M.D.*

NEWCASTLE

Throughout the nation, during the last decade, many efforts have been made, by many types of plans, to answer a public demand for lowering costs to the lower income class for medical care. It is quite true that much of this demand is the result of an overenthusiastic, if not hysteric, insistence by impractical and dreamy lay social reformers, on what they call "adequate medical care." Their definition of "adequate" is exaggerated, because it includes all services which in their rather utopian and pseudo-scientific opinion are "required." It is conceded, because provable, that the "demanded" services are sufficient. The "demanded" services comprise those accepted by the public and the medical profession as representing present needs.

The difference between the "demanded" and the alleged "required" services are largely dental, not medical, although the qualifying term "dental" is not stressed. These alleged demanded and required services also include vague and quite flexible public health measures, the value of which are at least debatable. But good health is an important matter to the individual. He responds to suggestion, and appealing suggestions soon become fixed beliefs on which he will act.

That many factors other than medical care are of importance is not stressed to the public, and we are not blameless, for we have preached the value of our services and have aided in establishing a profound belief in the public mind that if they might have all the benefit of the many procedures in our armamentarium, good health and long life would be assured. Naturally, the public insists on having access to everything we have available. Since these facilities are necessarily expensive, the costs are large, creating a difficult burden on the resources of those of limited means. But they believe that they must have these services, and if they are not easily procurable, means are demanded by which they may be obtained. Because of our much-altered social attitude, the general government is the source of all demanded supply, even if the end result of such supply is disastrous to those so supplied.

The ancient plan of distributing risk and costs by insurance contributions has an appeal, at least to the self-respecting and the thoughtful.

In a humanitarian as well as practical effort by professional groups to meet the growing and compelling demand for a working method of lowering costs of medical care to the low income and near indigent classes, the earlier plans provided for low cost insurance coverage sufficiently inclusive to meet every phase of an insured case. Since costs were held below real requirements, the deficits were assumed by the participating doctors by accepting low fees for complete services. If the participants (subscribers) could be held exclusively to the low-income and near-indigent groups, the profession might fairly carry the burden as a justifiable contribution to the general welfare. Unfortunately, human nature being what it is and has been, the humanitarian principles become obscured in the understandable desire to receive without compensatory giving, and the organizations become loaded with members who belong unfairly, thereby forcing a generous-minded profession to assume a financial burden which is unjust and which was not anticipated in the beginning.

The long and bitter experiences of our foreign brethren indicated a need for a method of meeting the just needs of the groups for whom the program was basically intended, yet block-off attempts of the really solvent groups to force the profession to carry on a plan with an economic loss was not contemplated.

Our own state association, viewing the matter from a practical standpoint, and not being lost in the haze of idealistic thinking, has adopted a sane, workable plan intended to meet the needs of the low-income groups, but elastic enough to make the insurance principle of cost distribution available to every economic group without making the physician the chief contributor.

No decent medical man will ever forget his obligation to the distressed. He accepts minimal compensation as a duty to them, and the fee schedules proposed will, to the overwhelming majority of physicians, be acceptable as full compensation for complete services to the deserving poor. To the better income group our plan gives acceptable and preknown assistance for unpredictable emergencies. It maintains the self-respect of the still existent men and women who abhor unnecessary charity, and it appeals to the business sense of the more affluent. It does not and cannot disturb the traditional right of a patient to choose his own physician, and it does not require any physician to enter into any form of contractual agreement to render service at any rate other than that dictated by his own judgment and fairness.

There will be only two contacts between our company and the physician; first, the physician has the duty of supplying the data affirming the claim and describing its form so the company may have a factual basis for claim allowance; and second, it will be the company's duty to see that payments

* Chairman of the Board of Incorporators, Mutual Medical Care, Inc.

reach the one performing the service on which the claim is based.

In a succeeding paper the details of the company's organization, its contracts, and its rates and methods, will be fully explained, showing the facts upon which its general actions and policies are based.

This company is not formed for individual profit; it represents a practical plan to meet the medical cost needs of all of our people, in a manner which the medical profession believes is fair, equitable, and just, both to the public and to the physician serving that public.

NORMAL HUMAN DRIED BLOOD PLASMA—ARMY-NAVY SURPLUS

The initial shipment of dried blood plasma by the Indiana State Board of Health has been made to all hospitals throughout the state which have indicated willingness to serve as a distribution center. As of March 1, 1946, more than six thousand 500 cc. units have been sent out to eighty-seven hospitals in Indiana. This plan of distribution was decided upon, after conference with the officials of the Indiana State Medical Association and the Indiana State Hospital Association, as being the most practical and expeditious method of making this surplus dried blood plasma available to the doctors throughout the state, and in turn back to the public which originally gave the blood. Through this plan the amount of shipping by the State Board of Health and of storage locally have been minimized. In instances where it is not convenient for outlying doctors to draw upon the hospital supply the State Board of Health will ship directly to such doctors upon request.

In keeping with the conditions required by the American Red Cross, no charge is to be made for the plasma itself, since it was originally donated by the public. However, this does not affect the normal charges for administering the plasma nor hospital charges for services rendered in association with the administering of the plasma.

The plan and arrangement for distribution of this plasma, which is surplus to present military needs, is another noteworthy service of the American Red Cross. A technical bulletin discussing this blood product in detail has been prepared for the American Red Cross by the Committee on Blood and Blood Derivatives of its Advisory Board on Health Services. The committee consists of Drs. Charles A. Janeway, chairman, Alfred Blalock, Edwin J. Cohn, Elmer L. DeGowin, Charles A. Doan, Robert F. Loeb, and Dr. John B. Alsever, Director of the Blood Donor Service of the American Red Cross. Because of the valuable information contained in this bulletin, and its timeliness, it is hereby reproduced:

Source and Distribution of the Surplus Plasma

The American Red Cross is furnishing dried blood plasma without charge for use in civilian medical practice. This material was prepared from blood collected by the American Red Cross for the Army and the Navy and has now been declared surplus to their needs. Supplies of this surplus plasma are provided to State Departments of Health by the American Red Cross for distribution to all physicians licensed to practice medicine and surgery and to all acceptable hospitals for use without charge for the product.

Description of the Plasma

This plasma has been prepared by commercial firms licensed by the National Institute of Health in the standard Army-Navy packages from blood collected by the American Red Cross. There are two package sizes: one contains 250 cc. original plasma (17 gm. plasma protein), the other 500 cc. (34 gm. plasma protein).

The *Pharmacopoeia of the United States* gives the following description of the product:

"Citrated normal human plasma may be dispensed as liquid plasma, as frozen plasma, or as dried plasma. Citrated normal plasma must be free from harmful substances detectable by animal inoculation, or by other means, and must not contain an excessive amount of preservative.

"Dried plasma—this is frozen plasma which has been dried from the frozen state under vacuum; it contains not more than 1 per cent moisture as determined by exposing a 1-2 gram sample, evenly distributed in a weighing bottle not less than 60 mm. in diameter in a vacuum desiccator at less than 1 mm. pressure over fresh phosphorous pentoxide at room temperature until the weight remains constant to the third decimal. It has a light yellow to deep cream color, is microscopically of a honeycomb-like structure, and shows no evidence of fusion.

Regulations—the outside label must bear the name 'Citrated Normal Human Plasma' and indicate the volume of original normal human plasma represented in the container, the manufacturer's lot number of the plasma, the name, address, and the license number of the manufacturer, and the date beyond which the quality of the contents may not be maintained."

The Standard Army-Navy Package

This consists of a sealed outer carton containing two metal cans. One holds the bottle of dried plasma, the other the distilled water for reconstitution of the plasma. The necessary tubing, needles, and other equipment required for reconstitution and administration of the plasma are also contained in the two metal cans. Instructions for reconstitution and administration are lithographed on the outside of the metal cans. Most of the packages also contain a report form to be filled out and mailed to the Army or Navy Medical Center. This report form may be used if desired for local or state studies, but *is not to be mailed to the Army or the Navy.*

Important Considerations in the Use of Dried Plasma

(a) *Dried plasma must be used within three hours after being put into solution.* If it were contaminated and allowed to stand several hours, sufficient bacterial growth could occur to produce fatal reactions.

(b) *Dried plasma must not be restored to the liquid state with diluent which is warmer than 100°F.* The reconstitution of dried plasma at a temperature appre-

ciably higher than normal body temperature may produce changes in the plasma proteins which could give rise to serious or fatal reactions.

(c) *Plasma must not be heated during administration.* Such a procedure may also cause reactions through altering the plasma proteins. The control of temperature is too difficult to make it safe to attempt to bring the plasma to body temperature for administration, and, furthermore, clinical research has proved that it is unnecessary to warm any solution given intravenously.

(d) *Dried plasma should be stored in a dry place where the temperature does not go below 35°F. or above 120°F.* The bottle of diluent may freeze and break below 32°F., and the dried plasma proteins may be altered above 120°F.

Indications for Transfusion

(a) The principal functions of whole blood and plasma transfusions may be classified as shown in the accompanying table.

(b) Plasma has also been shown to be of distinct value in the treatment of the shock which often exists in: 1. Crises of Addison's Disease; 2. Diabetic coma after rehydration; 3. Cholera and infant diarrhea; and as supporting treatment in: 4. Intractable ulcerative colitis.

Contraindications for Transfusion

There are few contraindications for blood or plasma transfusion, but these should be observed with extreme care. The presence of edema of the lungs due to congestive heart failure or severe pulmonary infections, particularly in infants, is almost always a contraindication. It has been shown that failure of the left side of the heart may be produced by the intravenous injection of as little as 200 cc. of saline in an individual with borderline compensation. In extreme cases edema of the lungs may be produced by the rapid injection of as little as 50 cc. of blood.

Adverse Reactions from the Administration of Human Plasma

Adverse reactions from the administration of the surplus dried plasma may be due to any one or a combination of the following:

(a) Heating plasma prior to or during administration.

(b) Bacterial contamination.

(c) Virus contamination.

The processing of plasma to the dried state does not as a rule inactivate a virus. Serum jaundice has been reported to be transmitted by blood and plasma transfusions even though the donor had only a sub-clinical infection. It is possible, therefore, that some lots of dried plasma may contain an active virus. Serum jaundice may occur from one to four months after the administration of contaminated plasma. Since it may be a severe and debilitating illness, physicians should use plasma only where definitely indicated.

(d) Failure to filter the plasma during administration.

Plasma should always be filtered. A filter is included in the administration set provided in the standard Army-Navy package of plasma.

(e) Improperly-cleaned intravenous equipment.

This should not be a factor if the set contained in the plasma package is employed for administration.

(f) Urticarial or anaphylactoid reactions.

The likelihood of these has been minimized through the use of fasting donors and the rejection of those with an active allergy.

(g) Circulatory embarrassment.

Reaction Rates: Army experience with this plasma showed that from 1 to 2 per cent of the plasma transfusions were followed by urticarial reactions, and that approximately 2.6 per cent were followed by chill and fever reactions.

Treatment of Shock with Citrated Plasma

The following paragraphs present a brief review of the use and dosage of plasma in shock accompanying hemorrhage, trauma, and burns. The lifesaving value of plasma in the treatment of shock is its most striking use in both civilian and military medicine.

In any evaluation of the fluid replacement therapy in shock one must consider the extent and degree of the lesion, the age and physical status of the patient, as well as other therapeutic measures undertaken. It is well known that minimal trauma may produce serious systemic reactions in the physically debilitated. In addition, the state of hydration of the patient must be estimated as accurately as possible. This is not always easy under emergency conditions, since laboratory studies may of necessity be deferred.

Shock due to hemorrhage or trauma: In the treatment of shock all that is possible must be done to prevent the initiating factors from acting a sufficiently long time to

INDICATIONS FOR TRANSFUSION*

Indication	*Whole blood*		*Plasma or serum*	
	Choice	*State (fresh or preserved)*	*Choice*	*State (fresh liquid, stored liquid, frozen, dried)*
Shock due to hemorrhage (traumatic shock)	First[1]	No preference	Second	No preference
Shock with hemoconcentration — initial treatment (burns, crush syndrome, and abdominal injuries)	Second	No preference	First	No preference
Hypoproteinemia	Second	No preference	First	No preference
Acute and chronic anemias	Imperative	No preference	Not indicated	
CO poisoning and methemoglobinemia	Imperative	No preference	Not indicated	
Immune therapy	Second	No preference	First	Fresh liquid, frozen, or dried
Deficiency of complement	Either	Fresh	Either	Fresh liquid, frozen, or dried
Deficiency of prothrombin	Either	Fresh	Either	Fresh liquid, frozen, or dried
Leukopenia and thrombocytopenia	Imperative	Fresh	Not indicated	
Hemophilia	First	Fresh	Second	Fresh liquid, frozen, or dried

* Table adapted from OCD Technical Manual, *The Operation of a Hospital Transfusion Service.*

[1] The recommendation of first and second choice is made on the assumption that both blood and plasma are immediately available.

produce clinical manifestations. The best treatment is, in other words, prevention. Patients exposed to obvious and sufficient precipitating factors must be treated as potential cases of shock without waiting for the appearance of clinical symptoms. Thus, a patient who has sustained extensive injury with crushing of tissues, with or without evident blood loss, should not be submitted to an extensive operative procedure involving general anesthesia without a dose of 250 to 500 cc. of undiluted or original plasma.

In shock due to massive hemorrhage the clinician must always bear in mind that the need for whole blood transfusions is urgent. Plasma transfusions will almost always tide the patient over if adequate amounts are given promptly enough, but whole blood is needed within a matter of hours if the red cell level has been reduced near the minimum compatible with adequate oxygenation of the body tissues. In any event the red cell level should be brought to normal as soon as possible to help create in the patient the optimal state for recovery.

Patients in shock, with such manifestations as cold, moist skin, grayish-blue color, feeble and rapid pulse, blood pressure unchanged or slightly lowered must be treated immediately and adequately. The management of early shock is as a rule a simple and successful procedure, whereas late shock is often very difficult to combat. This line of demarcation between early shock and late shock divides the patients who can be sucessfully treated with relatively small doses (250 to 750 cc. of undiluted plasma) and those in whom larger doses (750 to 1,500 cc. or more of undiluted plasma) must be employed repeatedly with only a fair chance of success.

The severe forms of shock are usually present in patients who regardless of the severity or nature of the initiating factors have been allowed to go for a period of time without adequate treatment. As a typical finding, they may show considerable drop in the total amount of plasma proteins. These patients also usually have a conspicuous drop in the blood pressure and particularly in the pulse pressure, rapid thready pulse, severe reduction of the skin temperature, collapsed veins, slow flow of blood from wounds, thirst, and low urinary output.** In these cases maximum doses of plasma must be given (1,500 to 3,000 cc. of undiluted plasma and even larger doses). The first 250 to 500 cc. should be given at once, and rapidly. Difficulty may be experienced in finding a suitable vein under these extreme conditions. To await a fall in the blood pressure before making a diagnosis of shock is reprehensible, but in the treatment of shock the blood pressure is a very good index by which to judge the efficiency and adequacy of treatment in general, and the dosage of plasma in particular.

Shock due to burns: Patients with burns require very large amounts of plasma and must be watched carefully for the first forty-eight hours if shock is to be avoided. A good general rule is that 1,000 cc. of whole (undiluted) plasma for every 10 per cent of body surface burned is required during the first twenty-four hours. Almost as much may be needed on the second day. The use of large quantities of plasma (2,000 cc. or more within twenty-four hours) may at times result in the development of pulmonary edema, particularly after the inhalation of fumes or in the presence of chest injury. It is often advisable to supplement plasma therapy with whole blood transfusions even in the first forty-eight hours to avoid subsequent anemia. After the first two days of treatment whole blood is always preferable to plasma.

Caution in the use of large doses of plasma: In the treatment of patients showing evidence of impairment of renal function the presence of a mercurial preservative in plasma should be borne in mind, since it may conceivably add to renal damage if more than 2,000 to 3,000 cc. of plasma are administered in the course of twenty-four hours. Ordinarily the rate of administration of plasma should not exceed one hundred fifty to three hundred drops (10 to 20 cc.) per minute. In advanced shock, where time is at a premium, it should be given as rapidly as possible—even to the extent of using two intravenous routes at the same time—until improvement is evident.

** Hemoconcentration may be present in severely dehydrated patients and in patients with severe burns or crush and abdominal injuries. Hemodilution is usually present in hemorrhage and skeletal trauma (which implies hemorrhage).

PRINCIPLES OF TRAINING

The general practitioner should never be satisfied with his medical knowledge. Medicine is progressing so rapidly each year that only by constant reading, observation, association with other physicians, frequent contacts with centers of learning, and other educational experiences can he hope to keep abreast.

The Board of General Practice plans to promote appropriate educational opportunities for the family doctor from the time he graduates from medical school until he retires from active practice.

The board wishes to establish broad, general principles of training of candidates for certification.

1. A knowledge of physiology, pharmacology, anatomy, bacteriology, and pathology in so far as they apply to the general practice of medicine is essential for continued progress of the individual. Such knowledge may be obtained by properly-arranged and supervised postgraduate courses.

2. In addition to knowledge of general medicine and its basic sciences, the general practitioner should have a genuine understanding of human nature and its complexities. He is the closest and most intimate friend of the family. To him they relate, without reservation, their most intimate problems; especially so when he wins their confidence. A genuine honest and sympathetic attitude manifested by him toward every member of the family is the basis of the high esteem he holds in their heart. Sacred are his duties and grave are his responsibilities. A constant vigilance and perseverance to qualify for that high calling is essential.

3. The board wishes to emphasize that time and training are but a means to the end of acquiring a broadness and depth of knowledge which the candidate must demonstrate in order to justify his certification in the General Practice of Medicine. The responsibility of acquiring the knowledge rests with the candidate, while the responsibility of maintaining the standard of knowledge required for certification devolves on the Board.

THE COMMITTEE ON CERTIFICATION OF THE GENERAL PRACTICE OF MEDICINE

Military News

Also released from active service with the United States Army at Drew Field, Georgia, is Major Floyd L. Grandstaff, of Decatur, who completed thirty-four months of service.

Following forty months' service in the Asiatic, Philippine, and Pacific areas, Captain Vance J. Chattin, of Washington, has resumed his practice there.

Dr. L. M. McNaughton, formerly of Petersburg, has opened an office in Washington since his discharge from service.

Major Kenneth O. Neumann, of Lafayette, has been released from Army service after one year's service at Camp Campbell, Kentucky, and two and one-half years at Camp Shanks, New York.

Lieutenant Colonel Brice E. Fitzgerald, formerly of Indianapolis, has moved to Logansport, where he is practicing medicine following his recent release from the armed forces.

Lieutenant Commander Maurice E. Gross, of Ladoga, has reopened his office there and resumed the practice of medicine, after an absence of more than four years, while he served in the United States Navy.

In service for forty-one months, Lieutenant Colonel Tyler J. Stroup, of Indianapolis, has been released from service. He was overseas for three years and served in various hospitals on New Caledonia, Guadalcanal, and Okinawa.

After serving for five years in the Army Medical Corps, Lieutenant Colonel Raymond A. Fleetwood is again practicing medicine in Nappanee. He was a member of the Officers' Reserve Corps, and reported for duty December 5, 1940, spending ten months overseas.

Major Russell L. Arbuckle, of Indianapolis, has returned to private practice following his recent release from the armed forces. Doctor Arbuckle entered the Army Medical Corps forty-six months ago, and served for three years in Africa and Italy.

Announcement has been made by Dr. Edgar Bridwell, formerly of Delphi, that he will open a new office in Bedford following his recent release from military service. Major Bridwell was placed on terminal leave from the Army on January second.

Another Peru physician who has been released from service and returned to private practice is Captain John E. Berkebile. He was with the Army of Occupation in Africa and Italy.

Captain Gilbert D. Rhea, of Greencastle, who served more than three and one-half years in the Army Medical Corps, recently received his discharge, and has reopened his office in Greencastle.

Captain Henry J. Zimmer, formerly of Mishawaka, has been released from service, and is now practicing in South Bend. Doctor Zimmer was in service for forty-six months, during which time he was stationed in Rome, Italy; Newark, New Jersey; and Syracuse, New York.

Captain Lowell G. Redding, of Markle, who entered service September 15, 1942, and who has been stationed at the Army Air Force Proving Ground, at Eglin Field, Florida, has been released from active duty and is at present at Markle, Indiana.

Dr. Wilbur F. Smith, of Indianapolis, who has been with the Medical Section of the Civil Aeronautics Administration, in Washington, D.C., has now resumed his practice in Indianapolis.

Entering the service on January 17, 1941, Colonel Robert D. Howell, of Indianapolis, spent twenty-two months in the South Pacific during his military career. Doctor Howell has returned to private practice.

In service for three years and seven months, Major E. Paul Tischer, of Indianapolis, has returned to his former office there. Doctor Tischer was assistant chief of medicine at the Army Air Force Regional Hospital, at Chanute Field, Illinois.

Captain C. E. Muhleman, of LaPorte, has returned from service and reopened his office there. Doctor Muhleman entered the Army Medical Corps in 1942, and for the past three and one-half years has been stationed at the Letterman General Hospital, in San Francisco.

After thirty-one months of overseas' service, Captain Robert J. Miller has returned and reopened an office in Evansville. Doctor Miller entered military service in June, 1942, and served with the Medical Corps in Africa, Egypt, Sicily, Italy, and China. In China he was in charge of a medical dispensary at a B-29 base.

Lieutenant Colonel Earl H. Hare, of Indianapolis, has returned to civilian life. Doctor Hare is chief medical officer of the Veterans' Hospital, with which he has been associated since 1931.

Captain R. A. Nason, of Garrett, has resumed his duties as city health officer at Garrett, a position he held prior to becoming a flight surgeon in the Air Corps.

Captain William C. McConnell, of Sunman, has resumed his practice there, after his recent release from the service. Doctor McConnell served with the Army Medical Corps, and spent thirty months overseas.

Captain Richart Schantz, of Remington, has completed a new office building in Remington, in which to resume his practice of medicine when he is discharged from service. Doctor Schantz suffered a severe leg injury while serving overseas.

Captain Earl P. Cripe, formerly of Redkey, plans to practice medicine in Bremen, following his recent release from service. Dr. Cripe served for three and one-half years with the Army Air Transport Command in the Southwest Pacific.

Of the 1,400,409 decorations given in World War II in recognition of meritorious service and gallantry, six per cent were received by Medical Department personnel, according to a biennial report by General George C. Marshall. These figures are exclusive of the Air Medal and the Purple Heart.

Commander Keith E. Selby, of South Bend, has returned and reopened offices there, after serving three and one-half years with the United States Navy. Approximately one-half of Doctor Selby's service was at the Great Lakes Naval Training Center, at Great Lakes, Illinois, and the remainder of the time was spent on Guam.

Major Alfred B. Scales, of Oakland City, is again engaged in the practice of medicine there, following fifty-two months with the armed forces. Overseas for twenty-two months, as chief of surgery with the 36th Evacuation Hospital, he served in New Guinea, Leyte, Luzon, and Japan.

Major Virgil McCarty, of Princeton, has been released from the Army and returned to practice there. Doctor McCarty spent forty-one months in the service, and during the greater part of that time he was chief of orthopedic surgery, and assistant chief of the surgical service at a station hospital at Camp Howze, Texas. He also served as assistant chief of orthopedic surgery at the Glennan General Hospital, Okmulgee, Oklahoma. When this hospital was closed he was transferred to the Brooke General Hospital, at Fort Sam Houston, Texas, where he remained until his discharge.

Just a few days before he went on inactive duty, Dr. John E. Wyttenbach, of Indianapolis, was notified of his promotion to a full colonelcy.

Major Warren V. Morris, of Monticello, has resumed his practice there, after serving in the Medical Corps for three and one-half years. He served overseas for twenty-six months, most of which time was spent in Germany.

Lieutenant George G. Morrison, of Portland, has received his discharge from the Army, after three and one-half years of service. Doctor Morrison has entered the George F. Geisinger Hospital in Pennsylvania, and will specialize in eye, ear, nose and throat work.

Dr. C. B. LaDine, of Indianapolis, formerly a lieutenant colonel in the Army Medical Corps, has resumed the private practice of medicine in a new office at Thirtieth and Sherman Drive, after spending thirty-four months overseas in Iceland and in the European Theatre. Doctor LaDine returned to the United States on June 4, 1945, to become executive officer of the Thayer General Hospital, at Nashville, Tennessee, until the hospital was closed the first of the year. He is now on terminal leave, and was in the Army a total of forty months.

Dr. Arthur N. Jay, of Indianapolis, who is on terminal leave until April, intends to return to practice in his former location. In service almost four years, Doctor Jay spent thirteen months at the station hospital at Camp Knox, Kentucky, then went to the Aleutians with the 30th Field Hospital, where he stayed almost a year, going from there to Camp Abbott, Oregon, where he stayed about twenty months as chief of medical service. At the time of his discharge Doctor Jay was on duty as chief of surgery at the German Prisoner of War Camp at Fort Lewis, Washington. Doctor Jay left service as a major.

Major Loniel H. Allen, of Bedford, recently has been discharged from the Army Air Forces. He joined the Army at Fort Benjamin Harrison in August, 1942, and was commissioned as captain and assigned to Camp Rucker, Alabama, as Plans and Training Officer and Chief of Surgery. In April, 1943, he was transferred to Goose Bay, Labrador, in the North Atlantic Wing of the Air Transport Command, where he remained for fifteen months as Base Surgeon. In October, 1944, he was transferred on temporary duty to attend the School of Aviation Medicine, at Randolph Field, Texas, graduating in January, 1945. In February, 1945, he graduated from the School of Applied Tactics, at Orlando, Florida. He was assigned as post surgeon at Dow Field, at Bangor, Maine, in March. Doctor Allen resumed his practice at Bedford, specializing in obstetrics and gynecology.

Formerly a major in the Army, Dr. Donald K. Winter, of Logansport, plans to open an office there. Doctor Winter spent forty-four months in the Medical Corps, during which time he operated a hospital in Nuernberg, Germany, and commanded the 36th Cavalry Medical Mechanized Corps, in Europe.

After more than three and one-half years of service in the United States Army Medical Corps, Lieutenant Colonel George A. McDowell, of Fort Wayne, has resumed his practice there. Doctor McDowell served seven and one-half months in the Philippines, and served as commanding officer of the 165th Station Hospital there. Doctor McDowell entered the service at Camp Grant, Illinois, and served at the Madigan General Hospital at Fort Lewis, Washington, and at the Regional Hospital at Fort Riley, Kansas, before going overseas.

Commander Joseph H. Stamper, of Middletown, was released from active duty in December. He entered the service in October, 1942, and reported for active duty at the Naval Hospital, at Bremerton, Washington. After five weeks he was sent to Pearl Harbor, where he served for eighteen months. He was then sent to the Great Lakes Naval Training Center, where he remained for one year. Again he was sent out, with the 7th Fleet, with which he served at Base Hospital No. 15, at Manus, in the Admiralties, and Base Hospital No. 2, at Subic Bay, Philippines.

Major Robert A. Staff, of Rockville, superintendent of the Indiana State Sanitorium at Rockville prior to his entry into the Armed Forces, is now on terminal leave, and recently visited his parents at Terre Haute. Doctor Staff entered the service in July, 1942, spent eighteen months in the states before going overseas, where he served for two years—in England, France, Belgium, Holland, and Germany, as a group flight surgeon for a fighter group with the Ninth Air Force. He has six battle stars and was awarded the Presidential Citation.

A "Welcome Home" dinner, sponsored by the Vanderburgh County Medical Society, was given on January 8, at Hotel McCurdy, at Evansville, honoring physicians from that area who have returned from the armed forces. Among those attending were: Drs. D. Patrick, Laverne Strough, Walter Dycus, W. L. Daves, E. A. King, Melvin Ritz, J. D. McDonald, Russel Springstun, W. D. Davidson, Morton Helper, Henry Faul, Dallas Fickas, Robert Miller, Charles Schneider, Roscoe Kleindorfer, W. L. Cole, Ermil Leslie, John Alexander, Fred Clements, Charles Leich, Pierce MacKenzie, Clarence Laubscher, H. Imes, Joe McCool, Charles Willis, R. Brown, A. Fowler, Paul Hart, and Ray Burnikel, all of Evansville.

While on terminal leave from the Army Medical Corps, Dr. Paul L. Long, of Anderson, has been promoted to lieutenant colonel. Colonel Long entered service in October, 1942, and served for twenty-five months in the Pacific as chief of the Medical Service, with the 17th Field Hospital. He returned to the States last January, and had been stationed at Percy Jones General Hospital, Battle Creek, Michigan. Doctor Long plans to resume his practice in Anderson.

Lieutenant Colonel Paul J. Fouts, of Indianapolis, has opened an office for the practice of general medicine, following his recent separation from the service. Doctor Fouts entered military service as a major in 1942, and until June, 1944, served with the 32nd General Hospital. At that time he was transferred to the 159th General Hospital, as chief of the Medical Service. In July, 1945, he returned to the United States as chief of the Outpatient Department of the Walter Reed Hospital, in Washington, D. C. He was discharged in November. Prior to his military service Doctor Fouts was with the Lilly Research Clinic at the Indianapolis City Hospital.

A Vincennes physician, Dr. Mordecai M. McDowell, has returned to civilian practice following his recent military career. Doctor McDowell served overseas with the 49th General Hospital Unit, and attained the rank of major. He is entitled to wear five ribbons with three combat stars and three gold stripes for overseas duty. He was called to active duty in the Medical Reserve Corps on April 1, 1941. He served at Brooke General Hospital, and Camp Robinson, Arkansas, before going overseas. His overseas duties included assignments as chief of the medical service, and chief of the section of the department of gastro-enterology. He returned from Manila in September, and has been on terminal leave.

Dr. Phillip T. Holland, of Bloomington, who entered active duty on January 21, 1942, has returned to Bloomington to practice general surgery, including industrial surgery. Doctor Holland, formerly Commander Holland, was first stationed at the Great Lakes Naval Hospital, then at the Office of Naval Officer Procurement, in Seattle, Washinton, and then on October 21, 1942, began sea duty on the *U. S. S. Mississippi.* During this tour of duty, which lasted until June 12, 1944, Doctor Holland covered about 85,000 nautical miles, and was in the Solomons, the Gilberts, the Marshalls, the Aleutians, and the Hebrides. After returning to the United States he was again stationed at the Great Lakes Naval Hospital, going from there to the United States Naval Training School, at Flint, Michigan. Since November, 1944, he was stationed at the U. S. Ammunition Depot, at Crane, Indiana, until his separation from service on February 8, 1946.

Announcement has been made by Dr. Bernard Karpel, of Mooresville, that he has reopened his office, after his recent discharge from the United States Army Air Forces with which he served for four and one-half years.

Captain Dick J. Steele, of Greencastle, announced recently that he had opened his office again, after having served in the armed forces for the past three and one-half years. Entering the Army in July, 1942, Doctor Steele was stationed at Gunter Field, Montgomery, Alabama, with the Eastern Flying Training Command, where he served for thirty-four months. Later he was transfered to the Army Services Forces, at Camp Blanding, Florida, where he was stationed until his release.

Formerly connected with the Veterans Hospital, at Indianapolis, for seven years prior to entering service in May, 1942, Captain Jack Reiss returned to the United States on February twelfth, after seeing much action with glider troops and paratroops. Captain Reiss was on duty throughout his entire Army career with the 326th Airborne Medical Company, with the famous 101st Airborne Division. His first station was at Camp Claibourne, Louisiana, and he went from there to Fort Bragg, North Carolina, where he was stationed until he went overseas in September, 1943. Captain Reiss has battle stars for Normandy, Holland, Bastogne, and Germany. He wears the Purple Heart with an oak leaf cluster, the Bronze Star Medal, the Combat Medical Badge, the Glider Badge, the Presidential Unit Citation with an oak leaf cluster, the Belgium fourragère and the Dutch fourragère. At present Captain Reiss has no definite plans for the future. His terminal leave ends the middle of April.

Lieutenant Colonel Paul G. Iske, of Indianapolis, is now on terminal leave, after nearly three years' service in the Armed Forces. Doctor Iske entered the service March 17, 1943, with the 32nd General Hospital, at Camp Bowie, Texas. Six weeks later he was transferred to the 119th Station Hospital, at Camp Swift, Texas, with which he went overseas on November 24, 1943. The hospital set up in Finschhafen, New Guinea, and remained there until August, 1945, when it was transferred to Hollandia, New Guinea. Doctor Iske served as chief of the Medical Service until January, 1945, when he became commanding officer. During the first part of the unit's service it received battle casualties from the Admiralty Islands, and then the Aitape and Hollandia actions. The War moved ahead so rapidly, however, that their patients then became chiefly tropical disease victims, particularly those suffering from scrub typhus, malaria, and dengue. During the last three months at Hollandia, Doctor Iske served as base surgeon. He plans to resume his practice of internal medicine with offices in the Hume Mansur Building, in Indianapolis.

After three and one-half years of military service, Captain Willis A. Fromhold, of Indianapolis, has reopened his offices for the practice of medicine. Doctor Fromhold enlisted in the Army in April, 1942, and his service included a year in the ETO, principally in England, Ireland, and Scotland. He was attached to the 111th General Hospital.

Dr. David A. McKinley's many friends will be pleased to know that he is back in the place that was so familiar to him a few years ago; now serving as Resident in Cardiology at the Indiana University Medical Center. (Captain McKinley served as flight surgeon on Saipan, and was critically wounded while trying to rescue a wounded pilot, but has fully recovered. He was later on Okinawa before returning to the United States.)

Lieutenant Colonel Dennis S. Megenhardt, who served overseas for thirty months, arrived in New York via plane in February, and has returned to Indianapolis.

From Colonel Megenhardt's service connections it is apparent that he has had some very interesting experiences, but in trying to get a story from him we encountered that certain reticence; however, there was one echo which redounded—"I'm glad to be back home!" (And to you, Colonel Megenhardt, we extend a "Welcome home!") We can well understand this statement, in view of his many transfers as each hospital unit demobilized.

Colonel Megenhardt entered service on March 17, 1943, when the 32nd General Hospital was activated, and went overseas with this unit about six months later, landing in England. He remained with the 32nd General Hospital until shortly after D-Day, when this unit moved on into Normandy, and he was transferred to the 104th General Hospital as chief of the Surgical Service. The 104th was located near Southhampton. He continued in that capacity until V-E Day, when the 104th General Hospital was returned to the States, and he was again transferred to the 186th General Hospital as chief surgeon of that unit. Later the 186th returned to the States, at which time he was again transferred to the 53rd General Hospital, at Malvern, as chief surgeon.

When the 53rd was sent home, he was transferred to the 163rd General Hospital, in London, where he served as chief of the Surgical Service, and consultant in Surgery for the United Kingdom. This all took place in England, where it appears that he was not only "a soldier among sovereigns, but a sovereign among soldiers."

Later he was transferred to Paris, with the 191st General Hospital, and from there he was sent to Rome, where he served as commanding officer of the 34th Station Hospital; and finally he was assigned to the 300th General Hospital, at Naples, serving as chief of the Surgical Service until he was returned to the United States.

Doctor Megenhardt will resume his practice in surgery on May first, and will open a new office at 1015 Hume Mansur Building, Indianapolis.

News Notes

Dr. W. E. Jenkinson, of Richmond, has been accepted for a years' residency in anesthesia at the Albany Hospital, in Albany, New York.

Dr. C. H. Mayfield, of Reynolds, was reappointed county health officer for a four-year term at a recent meeting of the White County Board of Commissioners.

Announcement has been made of the wedding of Miss Rosalie Berg, daughter of Mr. and Mrs. Joseph P. Berg, Sr., of Fort Wayne, and Dr. Roy R. McCoy, of Fort Wayne. The wedding took place on January twenty-sixth, at the St. Peter's Catholic Church, in Fort Wayne.

Dr. Charles R. Bird, of Indianapolis, has been appointed surgeon for the Indiana Department of the American Legion. In making the announcement, Henry E. Siebenmark, department commander, said that Doctor Bird's duties will consist chiefly of advising veterans in regard to claims for compensation and hospitalization. The appointment is the first of its kind, and Indiana is the first American Legion department to retain a paid medical consultant.

Dr. and Mrs. C. H. McCaskey of Indianapolis, recently made a "flying" trip to Mexico, where they spent three weeks touring the state. They visited the Pacific Coast, staying at Acapulco, then spent three days in Fortin, in the State of Mexico, and made a number of other trips throughout Mexico. While there, Dr. McCaskey visited the Institute of Cardiology, and was shown around by Dr. Guerra, the otolaryngologist. He says that the institution was as modern as any in the United States.

MEETING OF AMERICAN ASSOCIATION FOR THE STUDY OF GOITER

The annual meeting of the American Association for the Study of Goiter will be held at the Drake Hotel, in Chicago, Illinois, on June 20, 21, and 22. These dates will make it convenient for those who wish to attend the meeting of the American Medical Association in San Francisco, California, on July first, in that the dates will link. This is the first meeting of the Association since 1941, because so many of the members have been in the service. The Van Meter Prize Award has caused considerable interest. The Program Committee requests those who wish to participate in the program to send the title of their paper at once to the Chairman, Dr. S. F. Haines, of the Mayo Clinic, in Rochester, Minnesota, in order that programs may be printed and distributed promptly.

Succeeding the late Dr. Larue D. Carter, Dr. Murray DeArmond, of Indianapolis, was appointed to the three-member City Merit Commission, by Mayor Robert H. Tyndall. He will be the psychiatrist-member of the commission, which rules on the eligibility of applicants for jobs as policemen and firemen. Doctor DeArmond was a member of the commission from its start, in 1935, until 1941, when he entered the Army Medical Corps. He was discharged last October with the rank of lieutenant colonel.

"YOUR DOCTOR SPEAKS" EXHIBIT

Non-commissioned paintings by America's foremost artists, which have been used to illustrate the "Your Doctor Speaks" educational health campaign, sponsored by The Upjohn Company, are now on a tour of American museums and will be shown in every section of the country during the next few years. They will appear at the Sheldon Swope Art Gallery, at Terre Haute, during April.

A new organization, The Indiana Cancer Society, Incorporated, recently has been created, with William H. Ball, of Muncie, as president, and Mrs. A. L. Taggart, of Indianapolis, as secretary. The purpose of the organization is to collect and disseminate information concerning the symptoms, diagnosis, treatment, and prevention of cancer; and to aid, in cooperation with accredited physicians, in the establishment, development, equipment, and maintenance of hospitals, clinics, laboratories, and other facilities for the care of cancer patients, and for research into the cause and cure of cancer.

POSTGRADUATE COURSE IN OTORHINOLARYNGOLOGY

The annual Anatomical and Clinical Course in Otorhinolaryngology, sponsored by the Indiana University School of Medicine, will be held April 15 to 17, inclusive. There will be forty members in the class, representing ear, nose, and throat specialists from all parts throughout the United States. The course is under the direction of Dr. C. H. McCaskey, chairman of the Department of Otorhinolaryngology, and Dr. E. N. Kime, chairman of the Department of Anatomy. Other members of the staff of the Indiana University School of Medicine will assist in instruction courses.

The Indiana Opthalmology and Otorhinolaryngology Society will be host at a dinner given for the participants of the class on Sunday evening, April fourteenth, at 7:00 P.M., at the Columbia Club. Dr. Frederick A. Figi, of Rochester, Minnesota, will be the guest speaker, and will discuss "Tumors of the Nose and Throat."

The staff of the St. John's Hickey Memorial Hospital, at Anderson, has honored Dr. W. M. Miley, of Anderson, by naming the hospital library the Weir Miley Medical Library of St. John's Hospital.

A farewell party was given recently by members of the Madison County Medical Society, honoring Dr. Albert W. Collins, of Anderson, who has retired and moved to Wheeler, Mississippi, to take up future residence. Doctor Collins was one of the founders of the Emergency Clinic, in Anderson.

Another physician to retire from active practice, after nearly half a century of service, is Dr. Walter R. Hutcheson, of Greencastle. He is resting in St. Petersburg, Florida, at the present time, and will return to Greencastle later, but does not plan to resume the practice of medicine.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The Twelfth Annual Meeting of the College is scheduled to be held at the Sir Francis Drake Hotel, San Francisco, June 29-30, July 1-2.

The next oral and written examinations for Fellowship in the American College of Chest Physicians will be held at San Francisco on June 29, 1946. Applicants for Fellowship in the College who plan on taking the examination should communicate with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

NO NEW A.M.A. DIRECTORY UNTIL 1947

The American Medical Association reports as follows concerning the publication of a new edition of the *American Medical Directory.*

"Orders for the next (eighteenth) edition are not being accepted at this time, and copies of the latest edition, published in 1942, are no longer available. One of the current problems in the Directory Department is the difficulty of keeping the records up to date regarding the relocation of the thousands of physicians being released from military service. Principally through the cooperation of the physicians themselves, the secretaries of county and state medical societies, and the governmental agencies, considerable information is being received. About 20 per cent of the physicians are returning to their former office addresses or are obtaining new locations for practice, but the majority will first take refresher courses or serve residencies in hospitals. Every effort, nevertheless, is being made to obtain current information regarding all returning medical officers. Another problem that will delay the *Directory* is the shortage of necessary clerical help in our office and printing departments. Under ordinary circumstances, compilation and printing of a *Directory* require about twelve months. At present, however, it is doubtful whether a new *Directory* will be completed and ready for sale before the autumn of 1947. Medical officers particularly who read this comment and have not already notified the American Medical Association of their present location and status should do so at once, so that they may be correctly listed in the biographic files."

—*Journal A.M.A.*, Feb. 16, 1946.

After serving as Orange County Health Officer periodically for the past forty years, and consecutively since 1939, Dr. S. F. Teaford, of Paoli, has resigned because of ill health. He will be succeeded by Dr. Keith Hammond, of Paoli. Doctor Teaford recently gave up his regular practice of medicine, also, after approximately forty years of service.

ILLINOIS' REFRESHER COURSE IN OTOLARYNGOLOGY

A one-week Didactic and Clinical Refresher Course in Otolaryngology has been arranged for specialists in the field, from May 13 to 18, inclusive, at the University of Illinois College of Medicine. In addition, a special course in Broncho-Esophagology will be given from June 3 to 15, inclusive. It will consist of lectures, animal and cadaver demonstrations, diagnostic and surgical clinics. Applications for registration should include school of graduation, training, and experience.

For further information address the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The general oral and pathology examinations (Part II) for all candidates will be conducted at Chicago, Illinois, by the American Board of Obstetrics and Gynecology, May 6-11, 1946, at the Palmer House, in Chicago. Formal notice of the exact time of each candidate's examination will be sent several weeks in advance of the examination dates.

Candidates for re-examination in Part II must make written application to the Secretary's Office not later than April 15, 1946.

For further information and application blanks, address Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF THE HISTORY OF MEDICINE

Announcement has been made of the annual meeting of the American Association of the History of Medicine, which is to be held at Hotel Claridge, in Atlantic City, New Jersey, May 26 and 27, 1946. A meeting of the Council will be held at 3:00 P.M., Sunday, May 26, which all members of the Association are cordially invited to attend. On Monday, May 27, there will be morning and afternoon sessions, including the Garrison Lecture, a symposium commemorating the 200th anniversary of the birth of Benjamin Rush, and miscellaneous papers. The annual dinner will be held at the Claridge Hotel in the evening. Members who wish to present papers are asked to communicate with the secretary, W. B. McDaniel, 2d, Secretary, College of Physicians, 19 S. Twenty-second Street, Philadelphia 3, Pennsylvania.

Formerly assistant superintendent of the Logansport State Hospital, Dr. C. C. Chapin, of Logansport, became superintendent on January first, succeeding Dr. C. L. Williams, who assumed his new duties as director of the Indiana Mental Health Council. Dr. Chapin had served as assistant superintendent at Longcliff since 1941, and had also served in that capacity prior to 1934, when he entered private practice at Decatur, Illinois.

1946 CLINICAL CONGRESS OF AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons announces that arrangements have been completed for its Thirty-second Clinical Congress, at the Waldorf-Astoria Hotel, in New York, September 9 to 13, inclusive. Plans include the usual demonstrations, scientific sessions, panel discussions, symposia, forums, Hospital Standardization Conference, medical motion pictures, business meetings, and educational and technical exhibits. This will be the first Clinical Congress since 1941. Since that time, 2,744 surgeons have been received into fellowship in absentia, and for them the Convocation on the opening night of the Congress will be a long anticipated event.

A state-wide social hygiene association was formed recently at a meeting of the Indianapolis Social Hygiene Association, to strengthen the Venereal Disease Control Program in Indiana. Organization of the state-wide group is planned in Evansville, Terre Haute, South Bend, Muncie, Gary, and Fort Wayne, under the chairmanship of Harold R. West, president of the Board of Directors of the Indianapolis Association. Dr. Walter Clarke, executive director of the American Social Hygiene Association, was the principal speaker at the meeting. Other speakers were Dr. George W. Bowman, of the Indiana State Board of Health; Dr. Gerald F. Kempf, of the Indianapolis Board of Health; Dr. E. Vernon Hahn, president of the Indianapolis Medical Society; and Mayor Robert Tyndall, of Indianapolis.

CHICAGO INDUSTRIAL HEALTH CONFERENCE

The American Association of Industrial Physicians and Surgeons, of Chicago, invites the members of the Indiana State Medical Association, the hospitals, and Indiana medical educational institutions to participate in the presentation of exhibits during the Industrial Health Conference, which is to be held at the Sherman Hotel, in Chicago, from April 8 to 13, 1946. This conference, which is sponsored jointly by the American Association of Industrial Physicians and Surgeons, the American Industrial Hygienists Association, the Association of Governmental Industrial Hygienists, the American Association of Industrial Dentists, and the American Association of Industrial Nurses, will be one of the most outstanding conferences of this type ever held.

Appointment of Dr. Ray D. Miller, of Indianapolis, as university physician at Butler University was announced recently by the president of the university. Doctor Miller will serve as university physician for students and care for the athletic teams, in addition to his private practice.

PHILIPPINE LIBRARY APPEALS FOR DONATIONS

At the outbreak of World War II, the Scientific Library of the Bureau of Science, in Manila, had one of the largest and best-known collections of technical and scientific publications in that part of the Orient. This library was destroyed by the Japanese during the war.

An appeal has been received from the Commonwealth of the Philippines for assistance in rebuilding their library, stating that they will appreciate any publications or collections which can be donated now or in the future. They should be addressed to the Scientific Library, Bureau of Science, Manila, Philippines.

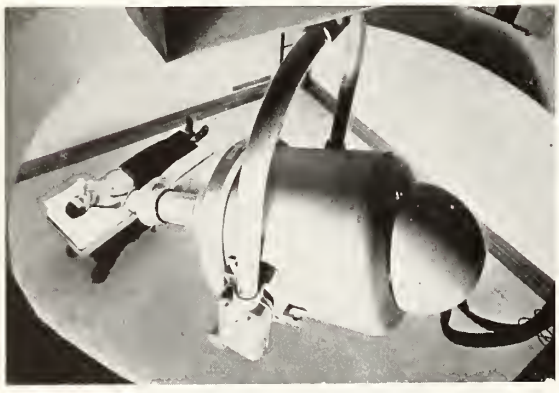
Appointment of twenty-eight attending physicians and senior medical consultants for the Indianapolis Veterans Administration Hospital was announced recently by the Dean's Committee of the Indiana University School of Medicine. All appointees are from the faculty of the medical school and are veterans of World Wars I or II. The Dean's Committee, which began work on January thirteenth, after a meeting with Veterans Administration medical officers, is comprised of: Dr. Matthew Winters, chairman; Drs. J. O. Ritchey, Henry O. Mertz, David A. Boyd, Raymond Beeler, George Bond, and W. D. Gatch, all of Indianapolis. The appointments are as follows: Internal Medicine—attending physicians, Drs. Brandt Steele, Donald Wood, Ralph Leser, James S. Browning and Bernard Rosenak; senior consultants, Drs. Cyrus J. Clark and I. J. Kwitney. General Surgery—attending physicians, Drs. Frederic W. Taylor, Jack Pilcher and Herbert Egbert; senior consultant, Dr. Harold N. Trusler. Ear, Nose and Throat—attending physician, Dr. Ralph J. McQuiston; senior consultant, Dr. Bert Ellis. Orthopedic Surgery—attending physician, Dr. Charles Thompson; senior consultant, Dr. George Garceau. Genito-Urinary Surgery — attending physicians (to serve six months in succession), Drs. John M. Young and R. D. Howell; senior consultant, Dr. Ernest Rupel. Dermatology—attending physician, Dr. Don E. Kelly; senior consultant, Dr. Frank M. Gastineau. Ophthalmology — attending physician, Dr. Edwin W. Dyar; senior consultant, Dr. J. M. Masters. Psychiatry — attending physicians (to serve six months in succession), Drs. Murray DeArmond and Alexander T. Ross; senior consultant, Dr. E. Rogers Smith. Radiology—senior consultant, Dr. Raymond Beeler. Clinical pathology — senior consultant, Dr. Horace Banks.

THE JOURNAL congratulates Dr. E. G. Grove, of Shelbyville, who recently completed his fiftieth year of medical practice. Honoring her husband on this occasion, Mrs. Grove entertained with a dinner party at their home on March sixth. Forty guests, including Shelby County physicians and their wives, were present for this delightful event. Dinner music consisted of compositions popular during the past fifty years. The main speaker of the evening was Dr. J. E. Ferrell, of Fortville, President of the Indiana State Medical Association, who gave a resumè of medicine during the past half-century.

UNIVERSITY OF MANILA NEEDS MEDICAL BOOKS

The Academy-International of Medicine, whose office is now located in Topeka, Kansas, is attempting to supply the destroyed medical library at the University of Manila with sufficient books to enable the school to operate. It is well known that the Japanese destroyed the university and its library until practically no usable equipment remained.

The Academy is appealing to the medical profession in the United States and Canada to donate books that may be sent to Manila. Already 10,903 individual publications are in transit, and many more are needed. Indiana doctors are invited to assist in this worth-while undertaking through contribution of books, periodicals, or cash. Anyone wishing to donate books should first write to The Academy-International of Medicine, Liberty Life Building, Topeka, Kansas, giving the title of the books, names of authors, and edition numbers of the books that are available, so as to avoid duplication. The donor will then be instructed which books are desired. If cash is given, the money will be used for the purchase of needed texts, arrangements having been made with publishers to sell books for this purpose at cost. Checks should be made payable to the Manila Library Fund, Academy-International of Medicine.



Cancer Gun—one-million-volt x-ray machine, used by the Army at the Walter Reed General Hospital, in Washington, D. C., is shown in action. The huge "gun," which can be accurately aimed at a small surface, is being trained on the clavicle region of the patient. To assist the technician in directing the rays, the area to be radiated has been marked out.

INDIANA UNIVERSITY NEWS NOTES

The possibility of the construction of a one-thousand-bed veterans' hospital, adjacent to the Indiana University Medical Center, in Indianapolis, is seen by university officials.

The proposal for a new veterans hospital, adjoining the medical center and supplementing the present veterans hospital has developed from a recent announcement by Major General Paul R. Hawley, chief medical officer of the Veterans Administration.

"Indiana University is much interested in the proposal that a new veterans hospital, in Indianapolis, supplementing the one of Cold Spring Road, be built adjacent to the University Medical Center," said President Herman B. Wells of the University. "General Hawley, who is a Hoosier, with both bachelor and honorary Doctor of Law degrees from the university, has stated that it is the policy of the Veterans Administration to place new hospitals near university medical centers. Plans have been announced for new hospitals for veterans near the medical centers of the University of Illinois and the University of Chicago. Therefore, it would be logical for any expansion of veterans hospital facilities in Indianapolis to be placed so as to have a close relationship to the University Medical Center and the nearby City Hospital.

"The advantages of such relationship are many and mutually advantageous to the veterans' hospital and the University's School of Medicine. The physicians at the veterans hospital thereby would have ready access to the library, laboratories, and clinical facilities of the School of Medicine. The members of the staff and students of the Schools of Medicine, Dentistry, and Nursing; and the Divisions of Medical Technology, Physical and Occupational Therapy, and Dietetics could be called upon for assistance by the staff of the veterans hospital. Physicians in private practice would find the close proximity of the two medical institutions of great convenience."

Similar views were expressed by Dean W. D. Gatch, of the Indiana University School of Medicine, who pointed out that as a result of a conference with General Hawley, when the Veterans Administration medical officer was in Indianapolis recently, a School of Medicine committee, under the chairmanship of Dr. Matthew Winters, is engaged in a study of relationships between the medical school and the present veterans hospital.

"I recognize the advantage of having an additional veterans hospital in the Indianapolis area near the University Medical Center," said Dr. Gatch, "but I must point out that this additional load means the need for additional facilities at the medical center, such as an enlargement of power plant, laundry, and laboratories. Our committee in its study has found itself in complete agreement with General Hawley's ideas."

Deaths

Henry C. Rogers, M.D., of Rockville, died at his home on January thirtieth, at the age of one hundred and one years. Doctor Rogers was a graduate of the Indiana Medical College, of Indianapolis, in 1876, and had practiced in Rockville for more than forty years. He had retired from practice some time ago.

Thomas Jesse Collings, M.D., of Rockville, died suddenly at his home, on March sixth, at the age of sixty-five. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1905, and began the practice of medicine in Mecca, going to Rockville later, where he had practiced for more than thirty years. He was a veteran of World War I, and was a member of the Parke-Vermillion County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Walter H. Vance, M.D., of Fort Wayne, died suddenly on February ninth, having been in ill health since being released from active duty with the Army, where he had served as a captain for sixteen months. He was forty-six years of age. Doctor Vance graduated from the Indiana University School of Medicine, in Indianapolis, in 1925, and had practiced in Fort Wayne for ten years, specializing in gynecology. He was a member of the Allen County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Lawton Eli Shank, M.D., formerly a resident of Angola, is presumed to be among the ninety-eight civilian employees who were killed by Japanese machine-gun fire on Wake Island, on October 7, 1943, according to evidence presented at war crime trials. Doctor Shank was employed as resident physician on Wake Island, by a construction company, holders of the contracts for construction of naval bases on the island. Doctor Shank graduated from the Indiana University School of Medicine in 1938, and was thirty-six years of age. He was a member of the California Medical Association—Pacific Naval Air Bases.

Silas Melvin Compton, M.D., of South Bend, died at the age of sixty-eight, at his home, on March fifth. Doctor Compton graduated from the Indiana University School of Medicine, in Indianapolis, in 1909, and was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Samuel Albert Prather, M.D., of Vincennes, died February eighteenth, in Indianapolis, after an illness of approximately one year. Doctor Prather graduated from the Medical College of Indiana, in Indianapolis, in 1905, and had practiced at the same location in Vincennes for forty years. He was a member of the Knox County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Charles C. Stroup, M.D., of Bloomington, died on February fourteenth after an illness of several years. He was seventy-three years of age. Doctor Stroup was a graduate of Rush Medical College, in Chicago, in 1900, and had engaged in the general practice of medicine in Bloomington until ill health caused him to retire several years ago. He had been city school physician in Bloomington for fourteen years.

William Shimer, M. D., of Indianapolis, died on March thirteenth, following a brief illness, at the age of sixty-seven. Doctor Shimer graduated from the Indiana Medical College School of Medicine of Purdue University, in Indianapolis, in 1906, and specialized in clinical pathology.

He had served as pathologist for the Indiana State Board of Health, as professor of Pathology at the Indiana Dental College, and as director and clinical pathologist at an Indianapolis hospital, later establishing private laboratories which he maintained until his death.

He was a member of American Society of Clinical Pathologists, the American Board of Pathology, the Indianapolis Medical Society, and the Indiana State Medical Association. He was also a Fellow of the American Medical Association.

JOURNAL COVER PAGE

The illustration used on the cover page of THE JOURNAL is a reproduction from a poster made by Lewis Wood, of Indianapolis, who is a senior at the Thomas Carr Howe High School and who received the first award in the poster contest sponsored by the Marion County Cancer Society. Each year the Marion County Cancer Society puts on such a contest as an educational medium in its Cancer Control Campaign, and commercial art students interested in poster work may participate. The "Victory Over Cancer" poster was prepared by this student under the direction of Mrs. Loreen De Waard, chairman of the poster contest and a teacher in the Art Department of the Thomas Carr Howe High School. He was awarded a Twenty-five Dollar Victory Bond for his winning poster. Dr. W. D. Gatch, Dean of the Indiana University School of Medicine, acted as one of the contest judges.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

February 18, 1946

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D.; Thomas A. Hendricks, executive secretary, and Ray E. Smith, assistant executive secretary and secretary of the bureau.

The secretary of the bureau reported that the executive secretary had represented the association at a luncheon of the Indiana Health Council on February 18, and had spoken on the prepayment medical care service.

A news release for daily newspapers, urging adequate breakfast, was approved.

THE NORTHERN TRI-STATE MEDICAL ASSOCIATION

The seventy-second annual meeting of The Northern Tri-State Medical Association will be held Tuesday, April 9, 1946, 8:30 A.M. to 4:30 P.M., at the Indiana Club, at South Bend, Indiana.

PROGRAM

"Welcome Address," by George M. Rosenheimer, M.D., of South Bend.

"Anti-Histaminic and Anti-Allergic Substances," by Bradford N. Carver, M.D., Summit, New Jersey.

"The Rh. Factor," by Edith L. Potter, M.D., Chicago Lying-In Hospital.

"Pediatric Emergencies," by James L. Wilson, M.D., Professor of Pediatrics, University of Michigan.

"Blood Substitutes," by William H. Gordon, M.D., Detroit, Michigan.

LUNCHEON

"Liberty Was Wonderful," by Professor Clarence E. Manion, Dean of the School of Law, University of Notre Dame.

"Our Socio-Economic Problem," by Floyd T. Romberger, M.D., Lafayette, President-Elect, Indiana State Medical Association.

"Thiouracil in Toxic Goiter," by Cyrus C. Sturgis, M.D., Professor of Medicine, University of Michigan.

"Infectious Hepatitis," by F. W. Hoffbauer, M.D., Division of Internal Medicine, University of Minnesota.

"The Control of Recurrent Ulcer," by Walter L. Palmer, M.D., Department of Medicine, University of Chicago.

All regularly-qualified physicians are cordially invited to attend this meeting and to become members of the Association.

COUNTY SOCIETY OFFICERS

ADAMS COUNTY MEDICAL SOCIETY
President, Benjamin E. Duke, Decatur
Vice-president, Harold Zwick, Decatur
Secretary-treasurer, John C. Carroll, Decatur

DEARBORN-OHIO COUNTY MEDICAL SOCIETY
President, M. J. McNeely, Dillsboro
Vice-president, J. M. Pfeifer, Lawrenceburg
Secretary-treasurer, J. C. Elliott, Guilford

GRANT COUNTY MEDICAL SOCIETY
President, Russell J. Baskett, Jonesboro
Vice-president, P. C. King, Swayzee
Secretary-treasurer, Russell W. Lavengood, Marion

JOHNSON COUNTY MEDICAL SOCIETY
President, Russell Wilson, Franklin
Vice-president, Walter Portteus, Franklin
Secretary-treasurer, Helen Barnes, Greenwood

KOSCIUSKO COUNTY MEDICAL SOCIETY
President, T. S. Schuldt, Princeton
Secretary-treasurer, L. A. Laird, North Webster

LA PORTE COUNTY MEDICAL SOCIETY
President, M. D. Gardner, Michigan City
Vice-president, A. R. Simon, La Porte
Secretary-treasurer, R. W. Kepler, La Porte

LAWRENCE COUNTY MEDICAL SOCIETY
President, Robert B. Smallwood, Bedford
Vice-president, L. H. Allen, Bedford
Secretary-treasurer, R. E. Wynne, Bedford

PERRY COUNTY MEDICAL SOCIETY
President, F. C. Glenn, Tell City
Vice-president, H. S. Dome, Tell City
Secretary-treasurer, D. A. Dukes, Tell City

VANDERBURGH COUNTY MEDICAL SOCIETY
President, C. A. Hartley, Jr., Evansville
Vice-president, P. J. V. Corcoran, Evansville
Secretary-treasurer, W. O. Denzer, Evansville

WARRICK COUNTY MEDICAL SOCIETY
President, J. T. Samples, Boonville
Vice-president, C. M. Wilhelmus, Newburgh
Secretary-treasurer, Ralph E. Zwickel, Newburgh

LOCAL SOCIETY REPORTS

Carroll County Medical Society members met at the Welcome Inn Cafe, in Delphi, on February twenty-eighth. Wives of the members were guests, as well as the principals of the county schools, and their wives. Members and guests numbered forty.

Cass County Medical Society members met at Logansport, on February fifteenth. Dr. Louis Spolyar, of Indianapolis, discussed "Newer Industrial Diseases." Seventeen members and three guests were present.

Daviess-Martin County Medical Society members held a business meeting in Washington, on March fifth. Fourteen members were present.

(Continued on Page xxx)

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The

Medical Protective Company

of

Fort Wayne, Indiana

(Continued from Page 208)

Clinton County Medical Society members met at the Clinton County Hospital, in Frankfort, on March fifth. Dr. C. A. Robison, of Frankfort, presented a paper on "Some Problems of Lighting." Thirteen members were present.

Delaware-Blackford County Medical Society members held a meeting at Hotel Roberts, in Muncie, on February nineteenth. Guest speakers were Dr. George M. Brother, of Indianapolis, who spoke on "The Use of Gamma Globulin in Measles," and Dr. Holland Thompson, of Indianapolis, who spoke on "Mass Chest X-ray for the Discovery of Tuberculosis." Twenty-eight members were present.

Dearborn-Ohio County Medical Society members met at the New Reagan Hotel, in Lawrenceburg, on January thirty-first. The eight members present discussed the reports of the House of Delegates and the Secretaries' Conference of the Indiana State Medical Association.

At another meeting, on February twenty-eighth, Dr. William A. Altemeier, of the Cincinnati University, Cincinnati, Ohio, gave a talk on "Penicillin." The talk was illustrated with lantern slides. This was a joint meeting with the local dentists, and members and guests numbered eighteen.

Elkhart County Medical Society members met at Hotel Elkhart, in Elkhart, on February seventh. A paper on "Differential Diagnosis of Acute Abdomen" was presented by Dr. Philip Thorek, of Chicago. The fifty-five members present also heard a report by Dr. A. C. Yoder, of Goshen, on the January twenty-seventh meeting of the House of Delegates.

At another meeting, on March seventh, the guest speaker was Dr. C. C. Maher, of Chicago, who discussed "Treatment of Cardiac Failure with Edema." Fifty members were present at this meeting.

Fayette-Franklin County Medical Society members met on February twelfth, at the McFarlan Hotel, in Connersville. Eight members were present.

Another meeting was held on March twelfth, when Dr. Will A. Thompson, of Liberty, and Dr. W. U. Kennedy, of New Castle, discussed The Medical Care Plan. Thirteen members were present.

Floyd County Medical Society members held a round table discussion on "Immunization" at a meeting in the New Albany Country Club, in New Albany, on February eighth, when twenty-one members were present.

At another meeting, on March eighth, the twenty-four members present discussed medical economics problems.

Fort Wayne (Allen County) Medical Society members held a meeting at the Lutheran Hospital, in Fort Wayne, on January eighth. A symposium was held on "Malaria," with presentation of charts on nine cases treated. Slides were also used, showing the microscopic pathology of malaria in different organs of the body. Forty-five members were present.

A regular business meeting was held at the Chamber of Commerce, in Fort Wayne, on January fifteenth, when forty members were present.

Grant County Medical Society members met in Marion, on January twenty-fourth. Dr. Bruce Stocking, of Muncie, discussed "X-rays."

Greene County Medical Society members met at the Freeman Greene County Hospital, in Linton, on February fourteenth. The fourteen members present held a business meeting and discussion of current medical problems.

Hendricks County Medical Society members held an election of officers at their meeting on January thirty-first, in Crawley's Hall, in Danville. A general discussion followed.

Henry County Medical Society members held their annual meeting on January twenty-fourth, at the Henry County Hospital, in New Castle, when officers were elected for the year.

Howard County Medical Society members held a meeting on March first, in the Francis Hotel, in Kokomo. The twenty-five members present heard Dr. E. Vernon Hahn, of Indianapolis, who spoke on "Methods of Psychoanalysis."

Kosciusko County Medical Society members met at Warsaw, on February nineteenth. Eight members were present.

LaPorte County Medical Society members held a meeting on February twenty-first, at the Rawley Hotel, in Michigan City. Guest speaker was Dr. Carl P. Huber, of Indianapolis, who spoke on "Bleeding During Pregnancy." Thirty-four members were present.

Marshall County Medical Society members met at Plymouth, on February fifth, when the fourteen members present were shown a film on "Wound Repair."



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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Indianapolis (Marion County) Medical Society members met on March fifth, at the St. Vincent Hospital Nurses' Home, in Indianapolis, when Dr. John A. Campbell, of Indianapolis, discussed "Survey Film Diagnosis of Abdominal Conditions," and Dr. Earl W. Mericle, of Indianapolis, discussed "Front Line Psychiatry."

On March twelfth, Dr. Lillian B. Mueller, of Indianapolis, discussed "Low Spinal Anesthesia for Obstetrical Deliveries—A Report of Two Hundred Cases." "Pathogenesis of the Vertebral Disc Syndrome" was presented by Dr. George J. Garceau, of Indianapolis.

At another meeting, on March nineteenth, Dr. Eugene F. Boggs, of Indianapolis, presented "Medical Care of the Aged," and Dr. William E. Gabe, of Indianapolis, discussed "Endometriosis."

At the March twenty-sixth meeting, Dr. Roy Lee Smith, of Indianapolis, gave a "Survey of Penicillin Therapy." Dr. Paul K. Cullen and Dr. Frank B. Ramsey, both of Indianapolis, were the discussants. Dr. John Eric Dalton, of Indianapolis, presented a "Survey of Chemotherapy of Syphilis," which was discussed by Dr. George W. Bowman, of Indianapolis.

Monroe County Medical Society members met on January thirtieth, at the Graham Hotel, in Bloomington.

At another meeting, at the Bloomington Country Club, on February twenty-seventh, Dr. Floyd T. Romberger, of Lafayette, was guest speaker. Twenty-six members were present.

Parke-Vermillion County Medical Society members held a business meeting at the Vermillion County Hospital, in Clinton, on February twenty-seventh. Thirteen members were present.

St. Joseph County Medical Society members met with the members of the St. Joseph County Dental Society in a joint meeting at Hotel LaSalle, in South Bend, on January twenty-third. Similar meetings are to be held semi-annually. The guest speaker for this meeting was Dr. Reed O. Dingman, associate professor at the University of Michigan Medical School, in Ann Arbor, who discussed lesions of the oral cavity, of interest to physicians and dentists.

Another meeting was held in Hotel LaSalle, in South Bend, on February twenty-seventh. Guest speaker was Dr. Paul C. Bucy, of Chicago, who discussed "Complications of Head Injuries."

Randolph County Medical Society members met in Winchester, on February eleventh. Dr. Ivan E. Brenner, of Winchester, discussed "The Use of Thiouracil." Eleven members were present.

At another meeting, on March eleventh, Dr. L. W. Painter, of Winchester, presented films on "Hemorrhoidectomy" and "Surgical Pathology of the Breast." Thirteen members were present.

Tippecanoe County Medical Society members met at the Lincoln Lodge, in Lafayette, on February twelfth. The fifty-five members who were present heard a paper on "Rheumatic Fever," by Dr. James O. Ritchey, of Indianapolis.

At another meeting, on March twelfth, Dr. Harvey W. Sigmond, of Indianapolis, spoke on "The Common Fractures." A motion picture was also shown, on "Abdomino-perineal Proctosigmoidectomy." A discussion followed pertaining to the use of amino acids before and after operations and in illnesses. Again, fifty-five members were present.

Tipton County Medical Society members discussed the care of veterans by civilian medical men, and plans for medical and surgical insurance, at its meeting at the Elks Home, in Tipton, on February fifth. Dr. A. E. Stouder, of Kempton, discussed "Cardiac Arrhythmias."

Vanderburgh County Medical Society members were addressed by Dr. J. K. Berman, of Indianapolis, who spoke on "Anomalies of the Alimentary Tract," at their meeting at the McCurdy Hotel, in Evansville, on February twelfth. The meeting was attended by fifty-five members.

Wabash County Medical Society members met at the Women's Clubhouse, in Wabash, on February sixth, when they were addressed by a Silver Lake dentist, Dr. E. A. Franks, on dental problems of interest to the general practitioner.

Warrick County Medical Society members met on January eighth, at the County Nurses' Office, in Boonville, for the election of officers. Five members were present.

Another meeting was held on February twelfth, at which five members were present.

Whitley County Medical Society members held a meeting at the Green Grill, in Churubusco, on February twelfth, when they were addressed by Dr. Ernest R. Carlo, and Dr. H. V. Scott, both of Fort Wayne.

The First Year

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Secretary—Mrs. Leon L. Blum, Terre Haute

The Winter issue of the *Bulletin* of the Woman's Auxiliary to the American Medical Association contains reports of officers, directors, and chairman of standing committees and state presidents. It is interesting to see what some of the other states are doing.

NOTICE!

The House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association will meet in Indianapolis on April 24 and 25. On Wednesday, April 24, Mrs. Frank Gastineau, president, will be hostess for the members of the state board only. The delegates and board members will meet Thursday at the Columbia Club for an all-day meeting.

COUNTY NEWS

Floyd The Woman's Auxiliary to the Floyd County Medical Society held a luncheon meeting on Friday, February eighth, in the Frances Cafeteria. Following the business meeting an interesting talk was given by Dr. Jefferson Streepey on his activities in the European Theatre of War.

Mrs. Frank Gastineau, president of the state auxiliary, was guest at a luncheon meeting on March fourteenth.

Lake: The Board of Directors met at the Woodmar Country Club for a luncheon and business session, at which time the delegates to the state convention in Indianapolis, in April, were elected.

The Woman's Auxiliary to the Lake County Medical Society met on February fourteenth at the Indiana University Extension Center at 9:00 P.M. Dr. William H. Howard, of Hammond, spoke on "Health Insurance," and Dr. David R. Johns, of East Chicago, president of the Indiana State Board of Health, also spoke. Following the addresses the auxiliary met for a social hour with members of the Lake County Medical Society, who held a meeting at the same time.

Madison: The Madison County Auxiliary was entertained on Monday, January twenty-first, at the home of Mrs. T. J. Stephenson, following a dinner at the Critchley Home. After a business session members enjoyed a program on "Old China and Its Origin," given by Mrs. Niel Laidler, guest speaker. She also presented a display of rare and unusual china.

Marion: On March twenty-ninth the Annual Public Relations Meeting was held in the Auditorium of L. S. Ayres & Co. An address was given by Dr. Leroy E. Burney, state health commissioner. "Let's Bring Indiana From the Bottom of the Health Heap" was the subject of his talk. The meeting closed with a tea.

Tippecanoe. The Woman's Auxiliary to the Tippecanoe County Medical Society held a luncheon on Friday, February eighth, at the Lafayette Country Club, with Mrs. John S. Morrison, retiring president, presiding. Current news on subjects of interest to the medical world were given by members, including reorganization of veterans' hospitals.

Books

RECEIVED

THE CARE OF THE AGED (GERIATRICS). Fifth edition. By Malford W. Thewlis, M.D., 500 pages with 44 illustrations. Fabrikoid. Price $8.00. The C. V. Mosby Company, St. Louis, 1946.

THE 1945 YEAR BOOK OF INDUSTRIAL AND ORTHOPEDIC SURGERY. Edited by Charles F. Painter, M.D., 432 pages with 225 illustrations. Fabrikoid. Price $3.00. The Year Book Publishers, Inc., Chicago, 1946.

TEXTBOOK OF OBSTETRICS. This edition is designed for the use of students and practitioners. (Stander's Third Revision) By Henricus J. Stander, M.D., Professor of Obstetrics and Gynecology, Cornell University Medical College, and Director of the Lying-In Hospital, New York City. 1277 pages with 740 illustrations, with several color plates. Fabrikoid. Price $10.00. D. Appleton-Century Company, New York, 1945.

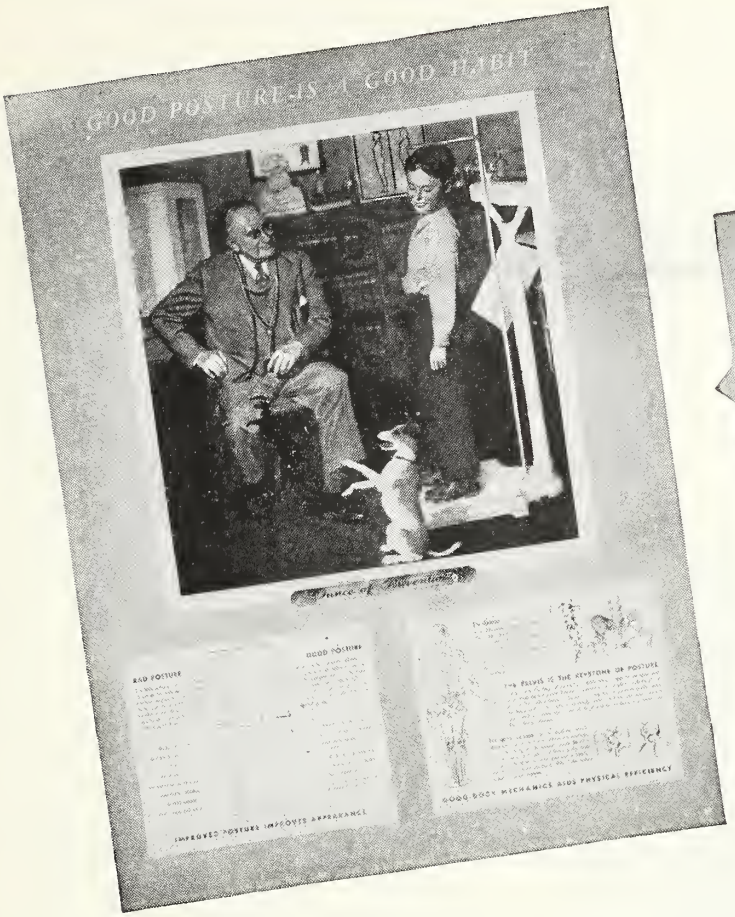
THE 1945 YEAR BOOK OF GENERAL MEDICINE. Edited by George F. Dick, M.D., J. Burns Amberson, M.D., George R. Minot, S.D., William B. Castle, M.D., William D. Stroud, M.D., and George B. Eusterman, M.D. 768 pages with 117 illustrations. Fabrikoid. Price $3.00. The Year Book Publishers, Inc., Chicago, 1945.

REVIEWED

HANDBOOK OF COMMUNICABLE DISEASES. By Franklin H. Top, M.D., M.P.H., Director, Division of Communicable Diseases and Epidemiology, Herman Kiefer Hospital and Detroit Department of Health. 682 pages with 73 text illustrations and 10 color plates. Cloth. Price $7.50. The C. V. Mosby Company, St. Louis, 1941.

The *Handbook of Communicable Diseases* is designed as a handy reference for the general practitioner. This book is written in an interesting style and illustrated with very excellent Kodachrome plates. The copyright date is 1941, and much of the chemotherapy advised is already outmoded, as even penicillin is not mentioned. It is based on an extensive clinical experience in the Herman Kiefer Hospital, Detroit, Michigan. The most instructive and unique information is contained in the tables in the appendix. One gives the percentage of attendant complications in a large number of cases, and the other gives the comparison between the admitting and the final diagnosis of every case treated. A study of these tables will alert the physician against every eventuality.

C.N.C.



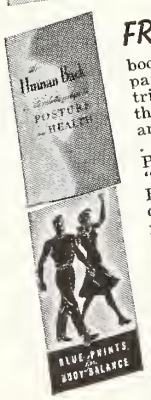
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NATIONAL POSTURE WEEK

Once again National Posture Week takes its place on the calendar of public health education as it dramatizes the sound and ethical year-round program focusing the attention of the country on the significance of good posture as one element in good health and physical fitness.

Since no field is more subject to the dangers of "glamorizing" and lay "experting," the Institute in all its appeals stresses the necessity of "seeing your physician" as the first step in the improvement of poor body mechanics. Distribution of authentic literature through schools, colleges, medical and government bodies; and industrial, professional and civic public health groups is an important part of the program. Press and radio give serious coverage.

We hope to merit the continued cooperation of the medical profession during the first post-war observance of National Posture Week as peace presents its varied problems to those charged with maintaining the health of the nation.



FREE: These two heavily illustrated booklets on posture prepared especially for distribution by physicians to their patients. Their titles are: "The Human Back . . . its relationship to Posture and Health" and "Blue Prints for Body Balance." Ask for the quantity you need on your professional letterhead. THE SAMUEL HIGBY CAMP INSTITUTE FOR BETTER POSTURE, Empire State Bldg., New York 1, N. Y. Founded by S. H. Camp & Company, Jackson, Mich.

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INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—December, 1945

Diseases	*Dec. 1945*	*Nov. 1945*	*Oct. 1945*	*Dec. 1944*	*Dec. 1943*
Chickenpox	300	159	82	506	222
Measles	40	18	17	25	460
Scarlet Fever	292	260	217	514	239
Smallpox	4	4	1	4	3
Typhoid Fever	2	7	6	1	3
Whooping Cough	92	105	113	42	92
Diphtheria	50	62	55	63	32
Influenza	4,290	410	26	37	2,431
Pneumonia	30	9	11	4	42
Mumps	30	47	22	89	74
Poliomyelitis	7	13	36	0	0
Cerebrospinal Meningitis	13	12	8	14	25
Malaria, Acquired Outside U. S.	4	10	11	0	1
Undulant Fever	3	4	4	8	3
Septic Sore Throat	9	13	13	2	0
Tetanus	3	3	1	0	0
Impetigo	9	13	1	5	0
Bacillary Dysentery	1	0	0	0	0
Conjunctivitis	3	0	1	0	0
Erysipelas	1	4	0	1	0
Food Poisoning	3	1	0	0	0
Infectious Jaundice	1	4	1	1	0
Rubella	1	1	5	6	120
Tuberculosis, Pulmonary	380	285	135	324	300
Tuberculosis, Other Forms	57	23	3	14	37

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT—JANUARY, 1946

Diseases	*Jan. 1946*	*Dec. 1945*	*Nov. 1945*	*Jan. 1945*	*Jan. 1944*
Chickenpox	297	300	159	563	387
Measles	212	40	18	27	1085
Scarlet Fever	302	292	260	521	451
Smallpox	2	4	4	6	2
Typhoid Fever	1	2	7	4	47
Whooping Cough	83	92	105	54	81
Diphtheria	62	50	62	24	61
Influenza	405	4290	410	28	573
Pneumonia	36	30	9	13	80
Mumps	49	30	47	220	120
Poliomyelitis	2	7	13	3	6
Cerebrospinal Meningitis	12	13	12	19	65
Undulant Fever	1	3	4	11	2
Encephalitis Lethargic	1	0	2	1	0
Erysipelas	2	1	4	1	0
Tularemia	3	0	2	6	5
Malaria, acquired outside U.S.	19	4	10	1	37
Conjunctivitis	1	3	0	0	0
Dysentery	4	1	1	0	2
Impetigo	11	9	13	2	3
Infectious Jaundice	1	1	4	0	1
Vincent's Angina	1	0	2	1	1
Septic Sore Throat	13	9	13	0	0
Rubella	2	1	1	4	65
Trichinosis	1	0	0	0	1
Food Poisoning	2	3	1	0	6
Tuberculosis, Pulmonary	196	380	285	215	250
Tuberculosis, other forms	8	57	23	10	3

APRIL IS CANCER CONTROL MONTH

THE JOURNAL

OF THE

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GERONTOLOGY AND THE EYE, WITH SOME REMARKS ON OLD AGE

C. W. RUTHERFORD, M.D.

INDIANAPOLIS

Preservation of ocular integrity is essential to the full powers of visual functions, without which the individual is handicapped in gainful pursuits and restricted in the enjoyment of leisure. Ocular deterioration in the aged is more often the result of factors outside the eye than of those within it, but signs of age detected in and about the eyes may prove useful in directing attention to processes going on in organs and tissues remote from the eye, and therefore are important in planning treatment for the individual who presents such eye signs.

The ocular characteristics of old age arise from two related processes: (1) Histologic alterations occur in vascular tissues which lead to impaired nutrition of the dependent structures. The blood vessel walls are altered by hyalin, fatty and connective tissue degeneration. (2) The individual becomes deficient in fat-soluble vitamins. The fat content of the orbit and subcutaneous tissues is reduced by migration or redistribution of fat. The globe recedes in position; the eyebrows and eyelashes become gray; the lids lose accustomed support so that ptosis, ectropion, entropion, and trichiasis develop. The conjunctiva is tinted yellow; the cornea becomes dull from loss of luster; arcus senilis appears; the iris undergoes some atrophy; the anterior chamber is shallow; and the lens takes on a grayish, yellowish, or brownish hue.

CORNEA

Arcus senilis (gerontoxon) is a narrow white ring near the margin of the cornea, separated from the margin by a narrower zone of clear cornea. The outer edge of the ring is sharply defined, while the inner edge fades imperceptibly into the unaffected cornea. The process begins in two places, above and below the pupil, but eventually the circle is complete. An infiltration of lipoidal material accounts for the ring. It does no harm and there is no treatment for it.

White limbus girdle superficially resembles arcus senilis. It is limited to parts habitually exposed while the lids are open.

Dystrophia adiposa corneae (fatty dystrophy) is a bilateral primary fatty degeneration exhibited as yellowish-white opacities; it indicates a state of low vitality in corneal tissues.

IRIS

Pale spots on the surface of the iris are called vitiligo. Xanthomatosis is seen as yellowish areas that do not consist of fat, differing in this respect from xanthelasma on the skin of the lids. In senile atrophy the structure is thin and gray; the pupillary border is pale from loss of pigment; connective tissue replaces fibers of the sphincter muscle, and the pupil is contracted (senile miosis). Hyalin changes stiffen the radial muscles, and it may be found difficult to dilate the pupil. In the iris atrophy seen in glaucoma the process is due to pressure ischemia; the iris is thin and flat, and bluish-white and brownish-white spots appear due to migration of pigment.

CATARACT

The crystalline lens is built up of cells that grow around the nucleus, and they continue to form throughout life. New cells compress older ones toward the center with loss of intercellular fluid. The center, or nucleus, becomes yellow to brown. The term cataract means an opaque lens through which rays of light cannot pass to form images on the retina. The color is usually gray to white. The condition is diagnosed with cer-

tainty by the biomicroscope, and with some assurance by the ophthalmoscope, but no diagnosis is defensible by inspection only; too often glaucoma was present when a diagnosis of cataract was made.

A feature of many cataracts in aging persons is the tendency, in earlier stages, to require weaker and weaker plus glasses, a change from weak plus to minus, or stronger and stronger minus glasses. This is the period during which the prospective cataract patient acquires so-called "second sight" and is able to read without glasses. The eye that has needed glasses for reading now has become focussed, without aid of glasses, for the reading distance. Second sight beguiles its possessor into believing in rejuvenation of sight, when actually it presages cataract. While the refraction is undergoing these modifications there also occur changes in the quality, amount, and axes of astigmatism with corresponding frequency.

Senile sclerosis of the lens sometimes presents a grayish reflex from the pupil, similar to that seen in cataract by inspection. With the ophthalmoscope the examiner may view the interior of the eye, indicating that the lens is transparent; the interior cannot be seen when complete cataract is present. The same observation is true in glaucoma; the interior of the eye can be seen unless cataract coexists. No examination of cataract is complete without testing by tonometer to determine intra-ocular tension or pressure. Since both cataract and glaucoma are characterized by slowly-progressive blindness it is most important to know if glaucoma is present.

VITREOUS HUMOR

Alterations in the appearance of the vitreous arise from disease as well as from changes incident to age. They are visible only with the ophthalmoscope. In the absence of demonstrable etiology from disease they are found in presenile and senile periods of life.

Synchysis scintillans consists of cholesterin crystals; by having the patient look down and then up while the vitreous is under observation, brightly-reflecting tinsel-like particles are seen to gravitate to the bottom of the vitreous chamber, and the rate at which they fall affords an indication of the degree of fluidity of the vitreous.

Asteriod hyalitis consists of spherical bodies composed of calcium soaps of fatty acids. These bodies seldom fall as the eye is moved, but undulate, which indicates that the vitreous is not in an unduly fluid state. Vitreous floaters consist of strings and clumps, with deposits of pigment on them; the vitreous is usually quite fluid. Floaters are interpreted as a process of degeneration, and so is fluid vitreous.

From the fifth decade of life onward some patients complain of being disturbed by seeing spots before their eyes. These spots arise from small areas of degeneration of the vitreous, and it is the projection of them into the field of vision, especially when reading, that annoys them. A shadow is cast on a printed word or any small object. The eye sees the word or object, but its retinal image is blurred. The patient is able to look directly at a spot when it is in the line of central vision, but it can be shifted aside, temporarily, by a quick movement of the eye. Areas of degeneration in the vitreous usually are visible to the examiner by using a plus 8 or 10 lens in the sight hole of the ophthalmoscope; since they are more readily detected while moving, the patient should be directed to move the eye at intervals.

To be differentiated are muscae volitantes, which are projected shadows of slight opacities left in the vitreous during embryologic development. Ordinarily the patient is aware of them only when fatigued or worried; they are never in the direct line of vision, but always aside, and they cannot be seen with the ophthalmoscope.

GLAUCOMA

This disease afflicts mankind at any time of life.* In aging persons it comes on in either of two types, the insidious and the acute congestive. In the former the aqueous is not filtered from the eye as rapidly as it is formed, and in the latter it is formed more rapidly than it can be filtered away. The only symptom in the insidious form is slowly-progressive loss of vision, similar to cataract in this respect, and because of the similarity it is often mistaken for cataract by a diagnosis ventured without adequate examination. The congestive form is ushered in more or less rapidly with severe pain in the head, and sometimes is accompanied by nausea and vomiting. The symptoms may mislead into a diagnosis of migraine, acute indigestion, and so forth. The attack often follows a profound emotional experience such as occurs with the unexpected death of a loved one from a sudden attack of severe illness or a serious accident. The sympathetic nervous system is overactive and aqueous is formed in too great amount.

RETINA AND CHOROID

Degeneration in the macular area appears at various stages of life. The type associated with old age is called "Junius-Kuhnt disease" or discoid degeneration of the macula. An opaque gray to yellow mass forms posterior to the retina, often preceded by a hemorrhage; the elevation is most apparent at the border of the lesion. The affected area spreads and changes features rapidly. Recurrent deep marginal hemorrhages and pigment shifts are common. Punctate white spots appear. The surface of the mass is uneven. Retinal and choroidal angiosclerosis develops. Angioid streaks are frequently associated. Early

* See paper under title Glaucoma elsewhere in this issue.

visual complaints are distorted images and subjective sensations of flashes of light. Central vision is lost rapidly, and all vision is reduced in due time. Eventually both eyes are involved. To be differentiated are sarcoma of the choroid, conglomerate tubercle, Coats' disease, and detachment of the retina at the macula.

OPTIC NERVE

Senile atrophy of the optic nerve develops when the nutrient vessels of the disk and nerve become so contracted or sclerosed that they can no longer carry sufficient blood. While tissues supplied by the smallest vessels are the first to suffer, larger vessels are likewise affected. It would be correct to associate senile optic atrophy and other circulatory deficiencies of the eye with sclerosis of the internal carotid artery or any of its branches.

EYELIDS AND EYE MUSCLES

Ptosis of the upper lid is more apparent than real; it is a pseudoptosis. Due to loss of retrobulbar fat the globe recedes into the orbit, so that the lid lacks the accustomed support. Weakness or impaired tone of the elevator muscle contributes to the appearance of ptosis. Extra-ocular muscles sometimes are affected in a similar manner; efforts to maintain motor co-ordination for binocular single vision give rise to fatigue with accompanying discomfort.

SOME REMARKS ON OLD AGE

The average age of the American is about twice what it was a half century ago. At that time, and for a century preceding, the average age at death was not more than thirty-one years; now it is nearly sixty-three. The gain largely represents progress in modern pediatric practice, which covers a comparable period and by which infant mortality has been greatly reduced. Similar progress in geriatrics would postpone the sclerosing process in body tissues, as well as those of the eye, and enable aging persons to continue longer in productive employment and retain their mental faculties for greater enjoyment of social opportunities.

Some aging patients complain that print becomes dim or may fade out entirely after short periods of reading, and they engage in a futile search for better glasses. The cause of the symptom is inadequate blood supply to the retina and possibly to cortical areas of vision; the lumina of the vessels may be contracted because of spasticity or thickening of the vessel walls without compensating rise in blood pressure. Frequent short rest intervals with the eyelids closed have been found very helpful.

Invasion of blood vessel walls by connective tissue cells constitutes a degree of angiosclerosis which may be construed as a strengthening of the structure. The vessel walls lose elasticity and the lumina are narrowed. To compensate for these deficiencies the heart must beat more forcibly to maintain a supply of blood to all parts of the body; this elevates the fluid pressure throughout the vascular system and constitutes hypertension of a kind. It has been noted that older patients accept this conception of stronger vessel walls with satisfaction; they are pleased to think their arteries have some added protection. Once the idea is implanted they are cautioned against heavy exercises or putting any sudden strain on the heart or vessels. Stevenson observed that "Age cannot bring, it must find, the philosophic mind." The tactful physician can accomplish much good by helping the individual attain this idyllic adjustment.

The number of birthday anniversaries has much less to do with the onset of old age than have the state and condition of the organs and tissues of the body and the mental outlook. Attitude and viewpoint often decide the time of onset of senility. The Psalmist set seventy years as the line of demarcation. From that time to the present generation of oldsters mankind has taken it for granted that decrepitude will appear at the age of seventy; at the same time the human mind has unconsciously solaced itself with the inference of implied freedom from old age vicissitudes until seventy.

Indigent persons usually are unemployable by the age of sixty-five, so old age assistance is available at that time for those who are otherwise eligible. National and state laws offer certain classified employees an option at sixty-five, with security, thus making elective retirement an inviting prospect for anyone who desires escape from further responsibility. Acceptance of the option subjects the individual to later disillusionment, for idleness is attractive to very few persons. Any theory that proposes universal retirement at some specified age is antithetic to the objectives and prospective advantages of geriatrics.

Until recent years only sporadic interest has been given the subject of health in those who are growing old. The following instances are samples from which judgment can be formed:

Osler** (1849-1919) is said to have made a remark to the effect that the history of the world would not have been altered materially if everyone had been chloroformed in middle life. A furore followed and persisted for a long time. When quiet was restored and calm judgment became possible the remark was construed by many to imply that once past the zenith of productive capacity man's abilities rapidly decline to inefficiency. Coué (1857-1926) sought to heal the sick and prolong life by teaching people to chant, "Every day in every way I'm feeling better and

** Acknowledgment is made to Dr. Edgar F. Kiser for some of the data in this paragraph.

better." To the same end, Horace Fletcher enjoined his followers to chew every morsel of food forty times; the practice came to be known as "fletcherizing." Coué, Fletcher and their ilk made but little impression on extending the span of life. No "one idea" can have universal application. Health problems are not as simple as that.

A novel philosophic concept may lack appeal unless introduced as a religious inspiration to build a new cult; while devotees may profess interest in health as a major activity, it is not evident that they are in the least concerned about the physical welfare of their overage members. The world's religions in general offer little except consolation to this social class.

Then what can be done for the old people? An organized, implemented approach to the subject is required before anything worth while can be accomplished. Dr. Thurman B. Rice for a decade has been expounding the creed of "Adding life to your years" (not adding years to your life, please notice) and urging new health legislation for the aged and aging. Governor Ralph F. Gates is vigilantly and aggressively health-minded. He believes *public* health is a commodity that can be purchased. He has set himself to prove it. The last Indiana General Assembly enacted a bill to establish a division of adult hygiene and geriatrics. Dr. William F. King was appointed as director, and he is eminently qualified. Indiana is on the alert. The medical schools may now begin teaching gerontology.

To whom may the aged look for *personal* advice and help? Obviously, to those physicians who envision human life as a succession of epochs, from prenatal through senile stages, with a sense of equal professional responsibility toward all epochal periods. The aged patient believes his infirmities can be ameliorated; the physician's office is his Mecca, and the physician is the high priest of his faith. In the one he finds a refuge wherein he puts his trust in the other. So he makes his pilgrimages and pays homage to the oracle. The senile person is justified in demanding medical care equal to that given the infant or to those in any other epochal period.

UVEITIS IN SOME SYSTEMIC DISEASES

CARL J. RUDOLPH, M.D.

SOUTH BEND

Uvea is a word taken from the Latin and means grape. The uvea of the eye when divested of the cornea and the sclera bears a resemblance to a grape. The uvea is composed of the choroid, ciliary body, and iris. Anatomically the choroid is continuous with the ciliary body at the ora serrata, and the ciliary body anteriorly gives way to the iris. Physiologically, the uvea provides nourishment to its adjacent tissues, directly or indirectly, as it is primarily a vascular layer.

Pathologically there is a very definite relationship in the involvement of adjacent parts of the uvea; however, in numerous instances only a small part of one unit may be involved. An iritis never exists without some ciliary involvement, and in severe cases the anterior choroid also may be affected. Because of the close superjacent proximity of the retina to the choroid, and its dependence upon the latter for nutrition, the retina is usually involved in disease of the choroid. Therein lies a catastrophe, for the retina is the seeing part of the eye and its destruction reduces the sight, depending directly upon the size of the lesion and its proximity to the macula or disk.

The uvea may be involved in numerous fashions; however, as this paper is being written primarily for the general practitioner, we will only mention some of these in passing: wounds of the uvea, endopthalmitis, phaco-anaphylactica, sympathetic opthalmitis, thrombosis, benign and malignant emboli, retinal hemorrhages, vascular sclerosis, angiospasticity, subchoroidal hemorrhages, sclero-uveitis, melanoma, intra-ocular hemorrhage, atrophic uveitis, traumatic uveitis, et cetera. The types of uveitis we shall primarily concern ourselves with are the types that the general practitioner will see either before the oculist sees the case, or in referral from the oculist to aid in establishing the etiology.

It commonly is assumed that the various forms of involvement of the uveal tract, iritis, iridocyclitis, uveitis and choroiditis are local manifestations of some systemic disease (Benedict).[1] The identification of the responsible systemic infection in the patient is usually quite difficult and taxes the diagnostic powers of both the opthalmologist and the internist. Not infrequently characteristics of a disease may arouse suspicion of a specific etiology. Nodules in the iris, as an illustration, may bring to mind Boeck's sarcoid, tuberculosis, syphilis, leprosy, and brucellosis. But the absence of nodules in no way eliminates the possibility of the aforementioned diseases.

Sarcoidosis of Boeck at the present time is appearing profusely in medical periodicals generally.

Longcope and Pierson[2] stated that sarcoidosis is described under the following names: Boeck's sarcoid, benign miliary lupoid, benign lympho-

[1] Benedict, W. L. and Wagener, H. P.: Ocular Lesions in the Sarcoidosis of Boeck, *Am. J. M. Sc.*, **203**:300 (Feb.) 1942.

[2] Longcope, W. T. and Pierson, J. W.: Boeck's Sarcoid (Sarcoidosis), *Bull. Johns Hopkins Hosp.* **60**:223 (April) 1937.

granulomatosis, Hutchinson-Boeck disease, et cetera. Pseudo, para, and non-caseating tuberculosis are terms that have also appeared in the literature.

Sarcoid was first described by Boeck[3] who emphasized the skin lesion and also mentioned lesions involving lymph glands, bones, mucous membranes, and internal organs. Schaumann's[4] descriptive designation of the disease, lymphogranulomatosis benigna, and his impression that it is an anergic phase of tuberculosis is certainly not without merit.

Following are some of the organs that may be involved in sarcoidosis:

Skin: This is the site for the most characteristic features of the disease, clinically. Firm, red, violaceous, or brownish swellings usually appear and are well demarcated from the surrounding skin.

Lungs: X-ray shows enlarged peribronchial lymph nodes, increased hilar shadows, and a marbled or reticulated appearance of the lungs resembling miliary tuberculosis, but with the infiltration extending from the root of the lungs toward the bases, rather than toward the upper lobes and apices.

Lymph nodes resemble a hard tubercle; there is a collection of large, poorly-staining epithelioid cells with a scanty marginal zone of lymphocytes and a few giant cells of the Langhans' type without caseation.

Bones show fine, punched-out areas of delicate lattice work. Sometimes there is irregular enlargement and distortion of the bones, but without involvement of the periosteum and joints.

Tonsils contain epithelioid tubercles.

The liver and spleen are frequently involved, which is a good example of sarcoid predilection for the reticulo-endothelial system.

The myocardium and pericardium were found to be involved by Longcope and Fisher.[5]

Eye: The iris nodules are often very large, not smooth but irregular, reddish yellow in appearance, and traversed by a number of fine branching vessels. Upon resolving these nodules are not followed by iris atrophy as in tubercle formation. The nodules of Boeck's sarcoid may involve the conjunctiva, but rarely the tarsus.

Goldberg and Newell[6] reported a case of a grayish-white subretinal tumor mass elevated four diopters and two disc diameters in size. The patient was a twenty-four-year-old negro soldier.

The lacrimal gland may be enlarged. Bilateral involvement together with bilateral involvement of the salivary glands constitutes Mikulicz's syndrome.

The similarity of Boeck's sarcoid to Heerfordt's[7] uveo-parotid fever has been described by so many authors that the possibility of these being one and the same disease should not be overlooked. Their contention is that in uveo-parotid fever the involvement of the parotid, uvea, and cranial nerves, which characterizes the disease entity, is merely an extension of the sarcoid into these structures. After all, there are few organs in the body that have not at one time or another been reported as being attacked by sarcoidosis.

The diagnosis of Boeck's sarcoid is confirmed by biopsy. The clinical examination of the skin and eyes may give the first clues to the etiology. X-ray examination of bones and lungs offer supporting evidence to sustain the diagnosis.

Brucellosis, also known as undulant fever or Malta fever: David Bruce[8] discovered the organism responsible for this condition in man; hence, the name. Bang[9] discovered a similar organism in cows with infectious abortion. "In man[10] the infected individual usually goes through an acute phase of the disease, characterized by fever, sweats, malaise, diffuse muscular pains and aches, loss of weight, and various more or less vague symptoms affecting any portion of the body. This acute attack may subside without sequelae, but usually the patient passes into a chronic phase which may last for years." This is characterized by an intermittent low grade fever and lassitude.

The history of ingesting raw milk or raw milk products is frequently helpful in arriving at a diagnosis that otherwise may be exceedingly elusive. Complement fixation test, opsonocytophagic index, agglutination test, and cutaneous sensitivity may be of aid.

Nodules of the iris, heavy epithelioid cell deposits on the posterior surface of the cornea, cyclitis, and elevated, somewhat circumscribed exudates in the choroid are the most frequent uveal findings. Other eye findings are papilledema,[11] nummular keratitis and phthisis bulbi (a result of severe uveitis).

Tuberculosis: Michel[12] first called attention to tuberculous uveitis and since then it has proved to be the most frequent etiologic factor in uveal disease. The diagnosis of tuberculous uveitis ex-

[3] Boeck, C.: Multiple Benign Sarkoid of the Skin, *J. Cutan. and Genito-Urin. Dis.*, **17**:543 (Dec.) 1899.

[4] Schaumann, J.: Benign Lymphogranuloma and Its Cutaneous Manifestations, *Brit. J. Dermat.*, **36**:515 (Dec.) 1924.

[5] Longcope, W. T., and Fisher, A. M.: Involvement of the Heart in Sarcoidosis, *J. Mt. Sinai Hosp.*, **8**:784 (Jan.-Feb.) 1942.

[6] Goldberg, S., and Newell, F. W.: Sarcoidosis with Retinal Involvement; Report of Two Cases, *Arch. Ophth.*, **32**:93 (Aug.) 1944.

[7] Heerfordt, C. F.: Über eine "Febris uveo-parotida subchronica," an der Glandula parotis und der Uvea des Auges lokalisiert und häufig mit Paresen Cerebrospinaler Nerven kompliziert, *Arch. f. Ophth.*, **70**:254 (April) 1909.

[8] Bruce, D.: Note on the Discovery of a Micro-organism in Malta Fever, *Practitioner*, **39**:161 (Sept.) 1887.

[9] Bang, B.: The Etiology of Epizootic Abortion, *J. Comp. Path. & Therap.*, **10**:125, 1897.

[10] Woods, A. C., and Guyton, J. S.: The Role of Sarcoid and Brucellosis in Uveitis, *Tr. Am. Acad. Ophth.*, **48**:248 (March-April) 1944.

[11] Rutherford, C. W.: Papilledema in Undulant Fever, *J.A.M.A.*, **104**:1490 (April 27) 1935.

[12] Michel, J.: Ueber Iris und Iritis, *Arch. f. Ophth.*, **27**(2): 171, 1881.

cites more controversy than any other question in ophthalmology (Duke Elder).[13] The reason for this is the extraordinary pleomorphism with which tubercle manifests itself in the uvea, owing to variations in the virulence and massiveness of the infection and the degree and nature of the resistance put up by the host, which depends on his state of immunity or sensitivity.

All writers are agreed that in patients with active pulmonary tuberculosis ocular lesions are rare. It is generally conceded that with the exception of the acute miliary form, which is part of a general dissemination over all of the body, the mode of infection of the eyes is not by a flooding of the blood stream with large numbers of bacilli, but rather by a mild, transient bacillemia resulting in an allergic sensitization.

The systemic ramification and repercussion of tuberculosis will not be discussed as the physician is already only too familiar with this disease.

Tubercles of the iris may vary in size from the small miliary tubercle to the large conglomerate tubercle; they are usually smooth elevations and the color varies from grayish-yellow to pink or almost red.

The ciliary body has been shown microscopically to be involved on numerous occasions, but because of its inaccessibility to inspection this may be difficult to determine clinically. Many pus cells can be seen easily on the posterior surface of the cornea, as in all types of iridocyclitis, by aid of the slit lamp and biomicroscope. The severity of the iritis may vary from a low grade type to a severe plastic or exudative type, depending upon whether it is an acute, a chronic, or an allergical manifestation. Choroidal involvement is seen to vary considerably, depending on the aforementioned factors; it is variously described as disseminated choroiditis, chronic uveitis (low grade), conglomerate, proliferative, miliary, acute and exudative (allergic). Pus cells in the vitreous are seen during the acute or active phase. Usually upon healing a white scar remains, surrounded by heavy pigmentation.

No part of the eye is immune to tuberculosis. Koyanagi[14] and Katznelson have reported tubercle bacilli in abundance in the discharge from an eye with panophthalmitis.

The treatment of tuberculosis, as we know it today, is of common knowledge. Suffice to say that it is not to be regarded as hopeless, and desensitization of the patient should be undertaken. I use the purified protein derivative. One should be cautioned against a focal reaction in the eye, in which instance it may be necessary to resort to subminimal dosages in the initiation of therapeusis. Local immunity in anterior segment lesions can be increased by paracentesis, which results in a plasmoid aqueous rich in immune bodies.

Syphilis does not involve the uvea as frequently as the early investigators were prone to believe. Any part of the eye may be involved, and some parts rather characteristically so: symptomatic pigmentary degeneration of the retina, primary optic atrophy, Argyll Robertson pupil, interstitial keratitis, salmon patch, and sixth nerve paralysis. Syphilis elsewhere in the body has been referred to as the great imitator. In this the eye is no exception. The lesions oftentimes are very misleading. Laboratory tests here are of more value than in other forms of uveitis (Wassermann, Kahn, Colloidal gold, et cetera).

Iritic lesions may vary from the early roseola (hyperemia) which appears early in acquired syphilis, to the large gumma which is usually pink, red, or violet color, and may be 3 mm. in diameter; it appears early or late (six months to ten years or more) in the course of the disease. Gummata of the iris is much more rare than of the ciliary body. The author has seen two cases of large condylomata of the iris in the Clinic of the New York Eye and Ear Infirmary; they were about 5 mm. in length. Condylomata or papulomata together with gummata constitute the syphilomata.

The pyramidal arrangement of pus cells on the posterior surface of the cornea has been regarded by some authors as pathognomonic. This may be a clue, the same as the dichotomization of vessels in tuberculous keratitis, but in itself not diagnostic.

The salt and pepper fundus is usually associated with congenital syphilis. Pigmentary disturbance in the periphery of the fundus, resembling bony spicules, has been confused with retinitis pigmentosa.

The appearance of syphilitic lesions of the fundus are many and various. Words are cumbersome in their description and experience only is of aid in their evaluation.

RHEUMATIC FEVER AND RHEUMATOID DIATHESIS

Formerly in the literature there appeared many and sundry eye involvements ascribed to rheumatism.

"Ocular pathology in which difficulty was experienced in determining its cause was relegated to the category of rheumatic fever. Frequently this would provide a 'catch all' for syphilis, tuberculosis, gonorrhea, and other diseases that may provide the basis for a joint involvement, and the true diagnosis would have eluded the examiner.

"It is our impression that the group-A hemolytic streptococcus, presumably causing rheumatic fever, may involve the eyes. However, we are convinced that rheumatic fever has in the past been accredited as the etiologic basis for eye conditions for which it was not responsible. This confusion is easily understood, as the rheumatic involvement with hemolytic streptococcus is far

[13] Duke-Elder, W. S.: *Text-Book of Ophthalmology,* St. Louis, Mosby, vol. 3, p. 2284, 1941.

[14] Koyanagi, Y.: Ein Fall von tuberkulöser Panophthalmie mit besonderer Berücksichtigung ihrer primären Lokalisation, *Klin. Monatsbl. f. Augenh.,* 93:37, 1934.

different from the ordinary reaction to this organism; the former being on an allergic basis.

"In a careful study of 105 cases of rheumatic fever, which was taken as a typical cross section of 650 cases in all, together with a review of the literature, we are convinced that there is no ocular pathologic change pathognomonic of rheumatic fever" (Rudolph[15]).

The rheumatoid diathesis are usually chronic in nature and of obscure etiology. They have been frequently associated in the past with ocular involvement, especially uveitis.

Reiter's syndrome (Caton) consists of a triad:

1. Acute nonspecific urethritis.
2. Mild purulent conjunctivitis or iritis in 60 per cent of the cases.
3. Acute polyarthritis (rheumatoid in type); also considerable weight loss occurs, with muscular atrophy and frequent recurrence. Ulceration of glans penis (balanitis circinata) has been observed. The etiology of this comparatively new syndrome has not been determined.

One of the most exhaustive studies of uveitis in recent years has been conducted at the Wilmer Eye Institute of the Johns Hopkins Hospital, by Alan Woods[16] and his staff. I quote their percentages found in a total of 562 patients:

Tuberculosis	49.7
Syphilis	10.5
Sarcoid	0.5
Brucellosis	0.4
Foci of infection	26.1
Gonorrhea	4.6
Nongranulomatous systemic diseases	5.9
Metabolic diseases	0.5
Miscellaneous	1.8

Tuberculosis as the etiology of uveitis, according to their figures, constitutes approximately one-half of all cases seen. We must bear in mind that different geographical areas will vary in their etiological percentages because of a difference in climate, altitude, races, et cetera.

Complications of uveitis are scleritis, interstitial keratitis, keratitis, neuroretinitis, complicated cataract, secondary glaucoma, and detachment of the retina.

The treatment of uveitis in general consists of removing or combatting the etiologic agent. Usually a mydriatic is employed to keep the eye at rest. "Local treatment of uveitis depends upon the part of the eye affected. It may be necessary to alternate the use of atropine with eserine, especially where there is degeneration of the pigment, as tension of the eye tends to rise and routine treatment cannot be followed in all cases" (Ruedemann).[17]

Supportive treatment will depend on the type of uveitis and the judgment of the physician. Foreign protein therapy is of definite value. Some have benefited by large doses of the sulfa drugs or penicillin; with these the author has had very little success.

CONCLUSION

In conclusion, it would seem highly probable that a number of cases of uveitis are due to the excitation of local allergic reaction by bacterial products liberated from some focus of infection in an apparently immune but really allergic patient. This is especially true if the tissue has been previously traumatized or devitalized by a past infection.

The chief difficulty in the accurate determination of etiology is due to the fact that some cases of uveitis may have several probable sources of infection, and other cases may have no demonstrable focus of infection. In either case uncertainty is quite obvious. The original or primary focus of infection may have entirely dissipated itself before the severity of the eye condition has forced the patient to seek medical consultation. The patient may have an upper respiratory infection involving tonsils and sinuses. If this is superimposed on an old syphilis, tuberculosis, gonorrhea, et cetera, the upper respiratory infection may resolve without proper attention being directed to it.

[15] Rudolph, C. J.: Eye Findings in Rheumatic Fever, *Am. J. Ophth.*, **28**:319 (March) 1945.

[16] Guyton, J. S., and Woods, A. C.: Etiology of Uveitis: A Clinical Study of 562 Cases, *Arch. Ophth.* **26**:983 (Dec.) 1941.

[17] Ruedemann, A. D.: Uveitis, *Cleveland Clin. Quart.*, **8**:58 (Jan.) 1941.

INDIANA'S PLAN IN REGARD TO CONSERVATION OF EYESIGHT

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1. Ophthalmia Neonatorum: Prevent by prompt instillation of silver nitrate, 1 per cent or 2 per cent solution, into the eyes of the newborn.
2. Squint or crossed eyes: Begin treatment not later than age two.
3. Discourage the use of high explosives in the hands of children. Reduce Fourth-of-July eye injuries.
4. Examination of school children for visual defects.
5. Avoid eyestrain. (A) Correct visual defects. (B) Prevent and treat diseases of the eye. (C) Install proper lighting. (D) Reasonable use of the eyes according to effects of use.
6. Help reduce hazards from industrial accidents.
7. Early detection and treatment of syphilis will reduce blindness.
8. Wipe out trachoma in Indiana.

NOTES ON GLAUCOMA FOR THE GENERAL PRACTITIONER

E. W. DYAR, M.D.

INDIANAPOLIS

In each issue of the Conservation of Vision Number of THE JOURNAL of the Indiana State Medical Association there has been, for the past few years, some notation or article pertaining to the disease of glaucoma. This disease should be included in any program wherein the visual efficiency of a group of people is to be considered.

No longer do we believe that glaucoma is an incurable condition. When the subject of "conservation of vision" comes to the attention of a group of practitioners of medicine, such a disease must be considered—perhaps not as to its prevention, but as to its control. A parallelism can easily be drawn between glaucoma and many of the other degenerative diseases peculiar to middle age or senility. When diagnosed early, arteriosclerosis, heart disease, diabetes, and nephritis are no longer considered as a cause for the early death of the individual. Likewise, glaucoma should no longer be considered as a condition which of itself necessarily causes blindness.

Those of the profession interested in geriatrics should consider glaucoma as one of the conditions which can be adequately treated, and the preservation of vision should be maintained throughout a normal life expectancy. As we understand more of the etiology, the refinement in early diagnosis, and the better regimentation of treatment in these cases, thus in direct proportion does our optimism rise in giving a favorable prognosis to such cases if they are seen early and treated adequately. It is also worthy of attention that in the oculist's conception of ocular hypertension the internist and/or the general practitioner play a highly necessary and fundamental role in the care of the case. The saying has been, "A sick eye in a sick body," and this with certain refinements of thought can all too frequently be the case. This is a disease which is not primary in the eye only, but which in a large percentage of cases have certain physical and psychiatric factors which have contributed to the disease process. The influence of the autonomic nervous system, the water balance, the acid-base reaction of the tissues, and the psychological pattern of the person's behavior are all intimately connected with the basic underlying problem.

"Glaucoma" is a word derived from the ancient Greek, which by definition means sea green. The physicians of that time described the degenerative process after it had gone so far that the edema of the cornea, the opacification of the lens, and the atrophy of the iris had all combined to produce a greenish cast to the anterior segment of the eyeball. Hence, it is a convenient term which has been handed down through generations of medical practice to include all diseases of the eyeball wherein the basic underlying factor is tension of the globe above and beyond what is necessary for the preservation of its shape, and still allow the metabolic processes to continue unhampered within. For the sake of convenience and understanding of this condition, let us classify glaucoma into four general categories: first, the uncompensated and compensated; and the second classification refers principally to etiology, which is either primary or secondary. Uncompensated glaucoma is better known as the acute or subacute form in which the diagnosis is relatively easy. These cases will manifest the intensely red eye with most of the injection about the corneoscleral junction; the dilated pupil; the shallow anterior chamber; extreme pain about the eye, radiating into the temple; and immediate loss of vision. On the other hand, the compensated form will show minor or no symptoms. The pupil is normal in size; the vision is probably fairly good, and there is no redness of the eye, and no pain.

Elevation of tension is not an uncommon complication of other eye diseases. Their general classification into "secondary" is made because it is assumed that in the majority of cases these eyes would not have had the glaucomatous process had not an antecedent eye disease been present. The most common ocular disease to produce glaucoma is iritis or iridocyclitis. The increase in the cellular content of the ocular fluids produces a mechanical blockage of the portals of egress, thus not allowing sufficient drainage. Injuries to the eye can also mechanically and by secondary inflammatory reaction produce the same type of condition. Swelling of the crystalline lens, either due to a normal cataractous process or due to trauma, will lead to the same end result. Fortunately comparatively rare, but nevertheless to be considered, are cases of infants who have hypertension of the eye because of congenital malformation of the structures in or about the area of filtration. On the other hand, the idiopathic or primary glaucoma has an etiology upon which we can not place a direct causal process. It seems, however, that in the majority of instances the primary defect is not in the filtration appartus itself, but rather upon some defect in the production of the ocular fluids. The entire process of ocular hypertension resolves itself into a mechanical balance between the formation and drainage of intra-ocular fluid, and its egress is controlled in a proper fashion so that the balance of pressure is maintained for the optimum conditions for vision and nutrition within the eye. The site of the main source of intra-ocular fluid is in or about the ciliary body. Whether or not this is a process of secretion or one analogous

to the formation of lymph and tissue fluids elsewhere in the body is a moot question. Most of the evidence we have at hand at present is in favor of the latter. If we consider the latter theory as being more nearly correct, we have a logical and rather tangible working basis for our therapy.

The chain of events which occur in acute congestive glaucoma bears much the same relationship to the eye, and particularly the ciliary body, as angioneurotic edema. The permeability of the capillaries in the ciliary body, which normally is very selective, suddenly becomes much greater, and there is a tremendous fluid interchange from the vascular system into the tissue spaces of the ciliary body. This results in edema of the ciliary body with the occupation of space in an area in which very little, if any, space is available for tissue fluids. This produces crowding of the ciliary body forward, carrying with it the lens and the iris, producing the shallow anterior chamber. This in turn encroaches upon the area of the eye wherein most of the filtration is accomplished. The entire process then becomes a vicious cycle. A certain amount of edema lessens filtration; the pressure is increased and this causes irritation, causing more obstruction to the filtration angle. As a result the pressure within the eye keeps increasing to a place where we have a stony globe, engorgement of the ciliary vessels, which can be seen through the translucent sclera. Fluid permeates into the cornea, disturbing the arrangement of the lamellae and producing the peculiar greenish cast. The sensory nerve supply to the area is stimulated, and there is pain throughout the orbit and the temple.

This description of what may happen in an eye which becomes uncompensated can be varied so that we can postulate a similar train of circumstances occurring to a lesser degree to fit the compensated; the distinction between the compensated and uncompensated being that in the latter case the edema in the vascular tunics of the eye is not of sufficient degree to obstruct the filtration area, which of itself will drain off the excess fluid and re-establish a normal intra-ocular tension. Very slight transitory edema of the ciliary body can occur, lasting perhaps only a short period and not sufficient to obstruct the filtration angle which takes care of the extra amount of fluid which accumulates in the eye within a period of a few hours. This will produce some ischemia to the retina, particularly in its peripheral portion with resulting damage to the nerve fibers in the retina itself. In such a condition and early in the disease process there may be no loss of central visual acuity because the fibers supplying the most acute portion of vision are not lost—only those which have to do with the extreme limits of the field of vision. As the periods of hypertension persist and probably increase in frequency and duration, more and more nerve fibers are lost until only central visual acuity is left, and that is also somewhat damaged. In the final stages there may be complete atrophy of all nerve fibers combined with atrophy of the nerve and excavation of the optic papilla, the "cupped disc" of glaucoma.

Those types of increased ocular tension of the congestive or uncompensated type are relatively easy to diagnose. It is not difficult for the physician to instantly visualize the fact that such eyes are candidates for immediate attention. Since the danger signals are so evident the majority of these cases are seen early and adequate treatment is instituted. The same criterion applies to those of a secondary nature inasmuch as there is usually some other symptom of ocular disease which gives the danger signal.

It is the primary or idiopathic form of the compensated or noninflammatory type which it is necessary to consider whenever conservation of vision is concerned. It is its very insidiousness that should keep us on the alert for the disease. A few of the signs to be kept in mind are: The subjective complaint of halos about artificial lights —some people describe them as rainbows. Dim or "smoky" halos are noted by some. Transitory headaches, particularly in the temporal region, which occur at night or during the early hours of the morning just before arising. Objectively, dilated pupils beyond an average diameter of four millimeters; the shallow anterior chamber; the slight injection of the small vessels immediately adjacent to the limbus; and in the latter stages deterioration of vision. Many of these people have been to the lay refractionist for repeated changes in their glasses. In some patients the symptoms have been so minimal, or their discrimination not of sufficient degree, that the first clue as to evidence of the disease will be found upon the taking of the tension routinely when examined for a refraction by an ophthalmologist.

Surgical intervention in these cases is to be considered only as a last resort. Much can be accomplished on these cases without establishing secondary means of drainage providing they are carefully supervised medically. They must be cautioned against excessive use of the eyes for near work. Reading under poor illumination is not a good thing. Careful examination of foci of infection should be made and eliminated. The blood pressure should be studied carefully at repeated intervals, and if necessary repeated during the same day. All signs of peripheral vascular disease must be noted and measures taken to alleviate them. The fluid intake should be watched and the amount of fluid content of the body kept at a minimum. These people should be cautioned not to engage in activities wherein there is excitement or nervous tension. The emotional reaction should be carefully watched, and if necessary the use of sedatives should be employed judiciously.

The use of miotics must be varied at intervals as to type, frequency, and concentration. Repeated examination of the visual field, tonometric measure-

ments, ophthalmoscopic examination, and patency of the filtration angle will act as guides in the progress of the case. It is to be remembered that the ideal case is kept under close scrutiny and supervision by both the ophthalmologist and the family physician. Any deterioration in the patient's physical condition will be detrimental to the ocular condition.

PENICILLIN IN OPHTHALMOLOGY

CHARLES L. MAHONEY, M.D.

TERRE HAUTE

The reports on the use of penicillin in ophthalmology are ever increasing. This antibiotic possesses properties which aid in explaining its effectiveness, its bacteriostatic effect in marked dilutions against many organisms, that is, the pyogenic cocci, gonococci, and its low tissue toxity; also the great solubility and diffusibility of its salts.

Florey, in 1943, wrote of good results from penicillin therapy of infection of the lid margins, conjunctiva, cornea, and tear sac. Bodenham cleared pyogenic cocci from granulating wounds secondary to burns of the eyelids and conjunctiva. Sorsby also in 1943 noted spectacular results in the local treatment of ophthalmia neonatorum when the gonococcus was the etiological agent. In these cases penicillin in the concentration of 100 to 2,500 Oxford units per cubic centimeter was used locally as solution.

Some common penicillin-sensitive organisms in the order of sensitivity are the B-hemolytic streptococcus, the gonococcus, and some forms of the staphylococcus, the pneumococcus, and the Treponema pallidum. The alpha and gamma Streptococcus are less sensitive, and the various strains of staphylococcus exhibit marked variation in sensitivity.

Penicillin lends itself readily to many methods of application, and as the cornea, conjunctiva, and lid margins are more accessible to topical applications, advantage of this factor is used to build high concentrations within these tissues. It may be administered locally either in the form of a solution or an ointment. The penicillin tissue content varies directly with the potency, and therefore the solution should be 5,000 to 10,000 units per cubic centimeter, and the ointment at least 1,000 units per gram. The use of the solution necessitates frequent application, that is, every thirty minutes unless used as a corneal bath. This, of course, adds to the patient's discomfiture. The ointment retains its potency longer than the solution at room temperature and is less likely to be contaminated by penicillin-inactivating organisms. It also does not require such frequent application; every two to three hours, both day and night, being sufficient to obtain a high concentration in the conjunctiva, cornea, and in the aqueous, especially if the corneal epithelium is not healthy. The injection of a more potent penicillin solution into the anterior chamber than hitherto reported is permissible since a more purified product is obtainable. The subconjunctival injection is not considered necessary since the topical application will achieve the same results with the exception of penicillin absorption into the vitreous. This can be greatly surpassed by direct injection into the vitreous. The intramuscular or intravenous administration of penicillin will no doubt clear many ocular infections. These methods are mandatory in cases such as orbital cellulitis, phlegmonous inflammations of the lids, acute lacrimal adenitis, et cetera.

Complications such as muscular abscesses following continuous intramuscular infusions at the site of the injection and caused by bacteria which are insensitive to penicillin have responded readily to drainage. Others, such as phlebitis, fever, muscular cramps, and vasomotor disturbances have largely disappeared with the advent of a more purified penicillin. General urticarial reactions, soreness of many of the joints, and some cases of transient bursitis have been attributed to penicillin. Local allergic reactions affecting the lids occur in about five per cent of the patients after local application for about three days. The skin of the lids becomes thick and dry, but rapidly returns to normal on withdrawing the antibiotic or by protecting the skin by the use of some waterproof emollient. It has been observed that patients with an allergic diathesis are more apt to show these reactions.

Inadequate treatment with penicillin may result in some degree of penicillin-resistance by the organism, if not in penicillin-fastness. Such a condition may be overcome by turning to one of the sulfonamides for a while, and then reverting to large doses of penicillin, or by taking advantage of a described synergetic action on the pathological organisms by using both penicillin and a sulfonamide.

The use of penicillin locally, previous to ophthalmic surgery, has lessened the number of postoperative intra-ocular infections, according to Berens. Its use in the procaine solution for retrobulbar anesthesia gives a sense of security against the possibility of introduced infection.

Rapid elimination of susceptible bacteria from infected lacrimal sacs can be accomplished by the instillation of a penicillin ointment into the sac, by means of a lacrimal syringe, once or twice daily. The following ointment formula has been quite successful in this method of application. It has also been found to be fairly stable, retaining more than 50 per cent of its potency at room temperature after six weeks.

PENICILLIN UNGUENTUM

Lanum anhydrous U.S.P.	17 per cent
White Petrolatum U.S.P.	51 per cent
Aq Dest.	5 per cent
Mineral Oil, light	22 per cent

One hundred thousand units of penicillin in the 5 per cent aq dest. are incorporated in 7 gm. of unguentum.

This must, of course, be made under sterile conditions, as certain contaminations would result in the production of penicillinase, which would inactivate the germicidal properties.

The application of penicillin ointment has given good results in blepharitis, especially of staphylococcic origin. Cases of gonococcal or pneumococcal conjunctivitis or keratitis have healed much more uniformly and spectacularly by penicillin than by the sulfonamides. A corneal ulcer due to a susceptible organism, even though complicated by a hypopyon, will respond much more quickly and more surely now that penicillin has been added to our armamentarium. Cases of scleritis and uveitis have not often shown a favorable course in the literature, and to date none have occurred in our practice which can be postulated as a cure for penicillin. By the same token it is difficult to give credit for cures of optic neuritis; however, some rather astonishing and happy results have occurred which encourage its continuance.

In capitulation, penicillin is the drug of choice in the pyogenic cocci and may be a valuable adjunct in infections caused by Treponema pallidum, C. diphtheriae, Clostridium welchii and Actinomyces bovis. There may be alleviation of symptoms in an intrinsic allergy and infections superimposed on other allergic conditions.

It is well to make at least a Gram's stain on any exudate, and it is preferable to have a culture in addition before starting therapy. This will allow a reasonable change in therapy if the response to penicillin treatment is poor.

It is preferable to give more penicillin than the infection requires, rather than too little.

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MYOPIA AND THE SCHOOL CHILD

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Myopia, or near-sightedness, is that form of refractive error of the eyes which is the opposite of hyperopia, or far-sightedness; the individual with myopia is able to see clearly those objects close to his eyes, but is forced to squint, or squeeze the eyelids, to clarify the images of distant objects. A myopic eye is essentially a diseased eye, and in most cases is due to elongation from overgrowth of the posterior segment of the eyeball; consequently, this disease develops in the preschool and early school periods of life. For the purpose of this paper relating to Conservation of Vision and myopia we shall not consider curvature and index myopia, which are relatively rare and unimportant in that they do not tend to become progressive. Eye physicians and all physicians should consider each and every early case of myopia as a potential case of progressive myopia until it is proved otherwise.

Practically all children are born with hyperopic eyes as evidenced by the small eyeball, the small orbit, and the small face and head; the eyeball grows at about the same rate as the brain, the orbit, and the face. The myopic eye, due to some unknown causative factor or factors, grows too rapidly and consequently becomes elongated before the restraining factor of puberty sets in. Thus, whatever the cause, the primary factor in the development of myopia is an aberration of development of the eyeball. Myopic changes may be said to occur only during the period of active growth, for elongation of an eye which has remained of normal dimensions up to the age of eighteen or twenty years is extremely rare.

In addition to the primary developmental fault, we must consider certain other factors which have no inconsiderable influence on the development of the degree of myopia; namely, excessive near work, bad ocular hygiene, and physical debility. These adjuvant factors cannot and should not be considered independent of each other, for they are definitely inter-related in their effect upon the myopic eye. Myopic children are nearly always excellent students; they are avaricious readers; they are prone to come home from school and "curl up" in a dark corner of the room and read—many of them take a book to read in bed; and they often tend to lie in the prone position on the floor and

read from books or magazines. Because their distant vision prevents them from becoming proficient, these children shun outdoor activities and sports, and are perfectly content to "pour over" any and all books and magazines. The lack of outdoor activities and the poor postural positions required in holding books close to the eyes, and excessive close work, are definite factors in producing an increase in the amount of myopia.

Myopia is a progressive disease which tends to become self-limited and arrested about the age of eighteen to twenty-one years. The writer has found, on the average, that most of these cases increase 0.50 diopter each year, although some years they may increase more rapidly and other years they progress at a lesser rate. The usual type of myopia begins around the age of six to ten years, and progresses about 0.50 diopter annually until the age of eighteen to twenty-one years is reached, when the condition becomes stabilized. This type of case might be called simple myopia. The rare case which steadily increases and does not tend to become arrested should be called progressive or malignant myopia; and the possibility of this should be considered by the eye physician until the condition is definitely arrested.

Because the elongation of the myopic eye is almost entirely in the posterior segment, the sclera becomes thinned and may be reduced to one-fourth its normal thickness; degenerative changes occur in the choroid, which lead to atrophic patches; the pigment layer of the retina loses much of its pigment and the fundus becomes tigroid and the patient sensitive to light; the bulging backwards of the posterior pole of the eye drags the retina and choroid from the temporal margin of the optic nerve head, producing a myopic conus or crescent; degenerative changes occur in the vitreous, which frequently liquefies, and large floaters are common. Complications take the form of retinal tears and hemorrhages, with more or less extensive detachment of the retina. This is often associated with trauma, such as boxing, et cetera, but may occur spontaneously.

Myopia cannot be cured once it is established, but every effort should be made to arrest its progress. This can be accomplished by the co-ordinated efforts of the school authorities and teachers, the parents, the family physician, and the eye physician.

All school children should have a careful study of their visual acuity at the beginning of each and every school year. Our school authorities should provide seats and desks that allow a proper postural position for the student along with adequate and proper illumination facilities. Teachers can cooperate by requesting eye examinations for those children who have trouble in seeing the blackboard or who persist in poor postural positions. The parents should make sure the child has sufficient hours of outdoor activities; that they do not "hold books close to their eyes"; that children are not allowed to read in bed or sit around and read when convalescing from a severe illness; and that the child has the attention and care of an eye physician when eye trouble is suspected. The family physician should attend to the general health of these patients with an abundance of proper food, exercise, fresh air, vitamins, and calcium. The eye physician should carefully refract these patients annually, test visual acuity at the six-month interval, and re-refract if the visual acuity shows signs of failing. The proper correction of the optical defect is the most efficient method of retarding the progress of the disease. Time should be taken to instruct the parents in the hygiene of myopia. The eye physician should be alert in detecting the earliest evidence of the pathology of myopia and be prepared to recommend appropriate measures to limit the extent of the damage by restricting near work, referring the child to "sight saving classes," if necessary, and advising against violent exercise which might lead to retinal detachment.

SUMMARY

Myopia is a disease of childhood and consequently of the school child. It has a tendency to progress until the age of eighteen to twenty-one, although a few cases are not arrested at this time and develop progressive or malignant myopia. The vision of these myopic children can be conserved by the co-ordinated help of the school authorities attending to properly-printed books and suitable school desks and illumination; the teachers by limiting the close work of these unfortunate children and being on the alert for the child who is unable to see the blackboard; the family physician by attending to the general health of the school child; the parents by controlling the amount of near work, the posture, and illumination during study at home; and, most important, the eye physician by carefully refracting these patients and rechecking vision at suitable intervals, and by seeing that all concerned appreciate and follow the hygiene of myopia.

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EYE COMPLICATIONS OF BRUCELLOSIS

Brucellosis, or undulant fever, is a cause of iritis and uveitis; the eye symptoms may closely resemble those of cases due to syphilis and tuberculosis. Other eye complications of this disease include disturbances in the extra-ocular muscles and choked disk.

PROGRESS IN INDUSTRIAL OPHTHALMOLOGY

HEDWIG S. KUHN, M.D.

HAMMOND

Prior to the war our responsibility with reference to the eyes of industrial employees fell into a few simple categories. First, the proper care of injuries sustained on the job, both in immediate first aid attention so vital in lime burns, for instance, and in the technique of subsequent surgery or treatment. The second category was the constant study of toxic products as they could or did affect the eye externally or through systemic action. Third, it was necessary to understand medicolegal procedures as workmen's compensation cases became ever more complicated. Here, through the efforts of the physician, the court, the employee, and the state, provision was made for a financial return to the injured worker. Then there was, of course, the vague field of Industrial Hygiene which, except for chemical hazards, rarely concerned itself with eyes in its study of plant environment and exposures controlled by safety devices and engineering rearrangement.

The story is vastly different now. There are a number of very specific problems on which to focus our attention in discussing eyes and visual problems as they are of particular concern in industry today. And here it is important to indicate that the word "occupational" needs to be, and has been, substituted for "industrial." Jobs are jobs—in a steel mill, in a bookkeeping office, or in a post office. At present these problems are of importance to management, to the employee, and in a large measure have become a new part of the responsibilities of medicine itself. Because of labor shortages during the war the blanket formula of "normal" distance acuity forming the basis of admission was no longer feasible. There was a sudden and tremendous need for more information about eyes and their *capacity* to fulfill the *demands* of particular jobs. Eyes were becoming an integral part of the whole. The conservation of wasted visual effort through a more comprehensive evaluation of what can rightly be called an individual's visual skills became a part of modern thinking. Applicants for jobs in industry have always been studied carefully from the standpoint of their training and knowledge of their particular craft. The co-ordination of hand and foot motion, the dexterity of hands themselves, the co-ordination between hands and eyes, and responsiveness to various types of signals have been studied by the employment department from the angle of aptitude. This is especially true in highly-technical jobs. These skills and aptitudes are a part of the accepted evaluation of an individual applying for a particular job. The only thing omitted in the past has been an evaluation of whether or not a person has the visual capacity to fulfill the visual demands of a highly-technical job. A few such relationships have been recognized. Railroads do not employ a locomotive engineer who is color blind, nor does commercial aviation employ a pilot with imperfect binocular vision. Under the stimulation of production urgencies during the war years tremendous strides were made in the understanding of visual qualities as they related to efficiency and safety. Also, because of the manpower shortage during this period, and the obvious unfairness of expecting a visually-handicapped man to increase his production, emphasis was placed on remedial and corrective procedures for those who did not meet the qualifications. These remedial procedures did not necessarily concern merely or even primarily distant vision only, nor was it a question of reading glasses only when the employees reported as patients to the office of their professional attendants. It became necessary to recognize the multitude of unusual work distances and to correct refractive errors on that basis, and to prescribe glasses for work which might be different than those worn for general purposes. As an example, the 200,000 loopers who work in the hosiery plants of this country must work at a distance of eight inches from their eyes. Not only should these employees be carefully selected before they are hired on the basis of their near acuity and their binocular co-ordination, but in most cases they need what has become to be known as an occupational correction—glasses for that particular job. These glasses should be left at the machine when the work period is over and not be used for any ordinary activity. A direct relationship between properly-corrected vision and job-production rate in loopers was reported by Professor Tiffin.[1] Labor turnover is reduced in these instances; the production record increases rapidly, and in turn the contents of the pay envelope are enlarged. There are many other jobs which demand specialized attention, such as small-parts assembly in radio and radar, filament work, and the myriad types of special inspection. As industry further mechanizes itself it must of necessity increase the need for watching control gauges of all descriptions, dials, changes in color values, detection of minute defects, and the synchronization and quick registry of indicators while executing certain maneuvers. It is for this reason that the relationship of visual skills and industrial production was not only a war responsibility but is an ever-increasing part of the postwar

[1] Tiffin, Joseph: *Industrial Psychology,* Prentice Hall, Inc. New York, N. Y. Chapter VI, page 124, 1942.

picture. As Dr. A. C. Snell has put it: "Since every job does not require the same degree of acuity or other qualities of vision, visual work requirements should be based on the minimum standards of vision found to be necessary for apt performance in specific occupations." It is important to remember in this connection that there is a difference between the terms visual "defect" and substandard visual performance. An actual defect is a clinical finding—uncorrectable acuity due to pathology, squint, or night blindness. Substandard visual performance means a lack of one or more visual skills demanded by the job—perfect stereopsis or a high level of color appreciation.

In order to find employees who need professional attention special techniques and instrumentation have been devised. Individuals who could not meet the visual requirements of the jobs they were applying for sought correction. Added responsibility was placed on the consulting ophthalmologist who was asked to outline a visual job-standard-testing program. Battery tests, designed for practical procedure, are not eye examinations in the usual sense that we use the term. Preliminary tests are done at the plant where careful and detailed records are made available to personnel and management as well as the medical staff. Likewise, office procedure as usually thought of in the handling of an eye patient for refraction, for injury, or for an admission examination for a specific job has been found to be inadequate. A knowledge of visual skills for all occupations is essential. A pharmacist, a file clerk, or a nose and throat specialist, when becoming presbyopic, may need occupational correction in addition to regular glasses. A new concept of the relationship between the consulting ophthalmologist and the plant has arisen. Management has become eye-conscious through intensive needling from the War Production Board during the war, from their insurance carriers, and from the men themselves through their unions. There is a growing awareness in industry that prescription-hardened lenses are not merchandise dispensed from a store room, but are the responsibility of the profession. It is no longer in line with modern thinking to have an employee bring in the prescription of the glasses he is wearing, which may be ten years old or may have been designed for the usual reading distance, and send that prescription to a commercial house with measurements for hardened lenses. His work may be as close as eight inches or as distant as thirty inches from his eyes. Whether he is a myope, a high hyperope, or a presbyope the glasses which he has been wearing at home and on the street may fail to meet the requirements for efficient seeing at his work distances. Here again the same principle holds true whether or not the lenses need to be hardened for protection. Goggles have been dispensed in the plants by laymen whose training was insufficient to detect errors in the prescription or make proper adjustments. "Eyes for the Job," the slogan developed during the war years, is a continuing slogan. Its meaning, as far as the profession goes, is refraction for special work distances, controlling the procedures that have to do with processed prescriptions for hardened lenses for the individual, and prescriptions for unusual and bizarre work distances where prisms and magnification play a part. From the standpoint of safety and efficiency, the prescription goggles have revolutionized the eye-protection programs. It is no longer necessary for workers to struggle with goggles which do not fit, or to wear coveralls which tilt the frames of glasses underneath, thus often distorting the image. Under the slogan, "Eyes for the Job," it is not always necessary to dismiss or reject the person failing to meet former arbitrary standards of admission. The varying standards which have been set up through the co-operation of medicine, industry, and psychology enable the personnel department to place before the applicant a variety of jobs which are within his visual capacities. Since all applicants or employees cannot be corrected to normal, and since special visual aptitudes are not required for many jobs, it is obviously unfair to the individual and unprofitable to industry to reject men on the basis of an arbitrary visual standard set for all departments and all jobs in a given plant.

In order that medical people can really understand the practical aspects of industrial eye problems, it is of first importance to establish intimate contact with the plants to which they are already advisers. This means, in all instances, visits to the plant so as to become familiar with the actual machinery and work of that particular plant, in order to study any unusual problems and to make informal contact with the workers themselves. The general medical man who goes to a major industry for several hours a day usually remains in the First Aid Room or Medical Division, and rarely goes out into the plant. This is true also of the specialists, particularly dermatologists and ophthalmologists. There is such a thing as an "industrial bedside manner" paralleling the personalized relationship between a doctor and his patient; namely, the doctor and employee *at his job*. A more complete "know-how" of the employee's environment is becoming increasingly important, not only for the ophthalmologist, but for all medical people working with industrial problems. To say that a man cannot return to work for a month after an uneventful appendectomy when all he does is to watch dials and record findings is unrealistic. Here, first-hand knowledge is important.

Through the war years much scientific research has been directed toward the further understanding of such things as radiation hazards, proper illumination for specific jobs, color contrast of machine parts themselves, as well as general environment and eye protection itself. Many agencies

have contributed enormously to increased knowledge of these matters through research organizations within and without the government, industrial hygiene groups, universities, industries themselves, general medical directors in plants, and their consulting ophthalmologists. This research includes work in dark adaptation, color perception and evaluation, the training of acuity as a cerebral process, a study of new toxic materials, the handling of such violent disruptions as epidemic keratoconjunctivitis; the procedures of removing intra-ocular foreign bodies (especially those of non-magnetic material such as alloys); and modern procedures of first aid in the treatment of chemical burns.

The practical results of this research and the accumulating literature have brought a new sense of responsibility on the part of the medical profession to society in general. It also has aroused an intense new interest. Industrial eye work viewed from its wider scope is challenging and exciting. The doctor is no longer completely dependent upon medical textbooks and treatises on disease for reference material. Industry itself is his laboratory, and the literature of psychology and management journals is rich in valuable material that has a direct bearing on visual problems.

In summarizing the discussion we note some of the specific categories that are now included in the field of industrial ophthalmology:

1. Proper first-aid procedures at the plant in the handling of eye injuries.
2. Revised surgical care of eye injuries and medical care of burns.
3. A wider knowledge of the constantly-changing picture of medicolegal procedures, workmen's compensation, and "second injury" funds.
4. Full knowledge of visual capacities as they match job demands.

This includes:

(a) Mass testing techniques within the plant (there are many), and the utilization of records for new fact-finding purposes.

(b) Job analyses from the standpoint of eyes and placement.

(c) Refraction for work distance.

(d) Orthoptic training for individuals with marked phorias who must do close work.

(e) Solving "visual bottlenecks" which may be found either in production or in the inspection department.

CONCOMITANT SQUINT

JAMES W. McEWEN, M.D.

TERRE HAUTE

The recent mobilization of the country's manpower for war, with compulsory physical examination of a large percentage of the male population, has given us valuable information regarding the incidence of various diseases and disabilities.

The high percentage of visual disability in Army selectees was called to my attention while serving on an Army physical examining board. Over a period of two years approximately one out of every ten men examined was rejected for full military service because of an ophthalmic defect. Comparison of my observations with those of others in various parts of the country shows that all were essentially the same. A very large number, 20 to 25 per cent of the total ophthalmic rejections, was due to squint associated with amblyopia, and a roughly equal number was rejected for unexplained amblyopia without squint. The amblyopia of most of this latter group was undoubtedly due to a previous squint in early life. Thus, we have approximately one-half of the ophthalmic rejections, or one man out of every twenty examined, who was rejected because of an amblyopia secondary to squint. We know that almost all of these visual cripples could have been saved by early adequate treatment. For this reason we believe a review of the subject is timely.

Concomitant squint may be convergent, divergent, or vertical. Most of the vertical type is seen in combination with one of the other varieties. Each of the above may also be classified as monocular or alternating, depending on whether one eye is used exclusively for fixation or the eyes fix alternately.

CONVERGENT SQUINT

This is the most common type, and it is also the type which causes most of the visual disability.

Etiology: The causes of this type of squint are high hyperopic refractive errors, marked anisometropia, defective fusion, amblyopia, and heredity.

Most of those with a convergent squint have a moderate to high degree of hyperopia. Such eyes require an excessive muscular and nervous effort to enable them to focus properly for clear vision, particularly at the near point. This effort causes an excessive stimulation of convergence, over-convergence, and squint.

A marked difference in refraction between the eyes, particularly a high astigmatic error in one eye, results in poor vision of that eye and makes it difficult or impossible for the images seen by the two eyes to be fused. The better eye is used for fixation, and the astigmatic eye squints.

The fusion faculty is defective or absent in some cases of squint. We assume that defective fusion is a cause of squint, for in no other way can we explain why some individuals with only a moderate hyperopia develop squint, while others with a very much higher error do not squint.

Amblyopia, because of its close association with squint, was formerly thought to be one of the chief causes. Amblyopia not due to a refractive error probably is a cause in a few cases, but we now know that the great bulk of amblyopia is secondary to the deviation and is a result, not a cause, of squint.

Certain refractive errors such as high hyperopia, astigmatism, or anisometropia may be inherited, and in this way a parent may pass on to a child a strong tendency to squint.

The exciting or immediate cause of the squint may be any condition which lowers the child's vitality. Often the deviation is first noticed during the course of one of the acute, febrile diseases of childhood, such as measles or scarlet fever. Prolonged use of the eyes for close work while sick in bed or confined indoors is probably also a factor.

Clinical signs: Convergent squint appears very early in childhood, sometimes during the first year of life; much more frequently in the second or third year; and much less often after the age of three. The deviation at first appears only occasionally, usually when the child is tired or when the attention is focussed on a near object. The condition becomes more frequent, and if no treatment is instituted it soon becomes fixed.

Diagnosis: The diagnosis is evident at a glance in the higher degrees of squint. If the apparent deviation is small, the cover test may be used to determine its presence or absence. This test consists in having the child look at a light or other object of interest held in the examiner's hand. The child's eyes are then alternately covered with a small card. If convergent squint exists, each eye will be seen to abduct or move away from the nose as it is uncovered, and the card switched so as to cover the other eye. Children with infantile epicanthus, and those with very small interpupillary distance, sometimes appear to squint. The cover test will show that the deviation is only apparent.

Treatment: This should be begun as soon as the diagnosis is established. No delay should be permitted for any reason. A child is never too young to begin treatment. Delay in treating monocular squint will nearly always result in a permanent disability due to amblyopia.

Careful estimation of the amount of deviation should be made before beginning treatment. This can best be determined in very young children by the corneal reflex test (Hirschberg). The child looks at a light held about a foot in front of him. The position of the light reflex on the cornea of the deviating eye is noted by the examiner. The degree of deviation, in degrees, is computed by multiplying the distance of the reflex from the center of the cornea, in millimeters, by eight. The cover test can be used on older children whose attention can be held for a longer period. This test, using prisms to stop the movement of the squinting eye, is the most simple, accurate method of measuring squint.

Refraction is the first step in treatment. This should be done under full atropine cycloplegia and the full correction prescribed for constant wear. Following this the child should be observed frequently as to the amount of deviation and visual acuity in order to determine the progress.

Treatment of the amblyopia, if present, is very important. The only successful method in very young children is complete occlusion of the better or fixing eye. This forces the child to use the squinting eye and improves its acuity. Occlusion should be continued for two or three months with frequent visual checks to guard against loss of vision in the covered eye. Amblyopia in older children can sometimes be improved by regular intensive treatment with a major amblyoscope. This form of treatment requires more attention and co-operation than can usually be obtained in a child under five years of age.

Surgery should be undertaken as soon as it is evident that there is no more improvement in the amount of deviation and in visual acuity from the treatment already outlined. This stage will usually be reached in a period of six months or less from the time treatment is begun.

Surgical procedures for the correction of squint are of two general types: those devised to lessen the action of a muscle, and those designed to increase a muscle's action. Both types are used in the treatment of convergent strabismus. The Jameson recession or one of its many variations is the preferred procedure of the first type. The operations which increase muscle action are of two main types: the resections, which shorten the muscle; and the advancements, which change the insertion of the muscle. These may be combined for a maximum effect. Choice of operation is based on the type of squint, the amount of correction necessary, and the preference of the surgeon. The squinting eye is operated first, and if any deviation remains the nonsquinting eye is operated. Small deviations of twenty degrees or less may be corrected by recession of the internal rectus. Higher degrees require in addition a resection or advancement of the external rectus. Correction of alternating convergent squint is best done by bilateral recession of the internal rectus.

Following surgery for monocular squint, the child's vision should be checked at regular intervals, and the fixing eye should be occluded if necessary. Training of fusion and stimulation of vision should begin, using one of the major amblyoscopes, as soon as the child is old enough to co-operate. By the use of varying intensity of illumination in the two eyes the difference in acuity may be overcome and fusion more easily accomplished. Formerly vision of 6/15 or better in the amblyopic

eye was thought necessary for successful orthoptic training, but more recently some observers report that they have successfully treated patients having vision as low as 6/60 in one eye. This is done by the use of very large targets, which the child can see in spite of a central scotoma, by the use of the more peripheral portions of the macular area of the retina. The cases which have only slight amblyopia may be treated successfully with ordinary stereoscope and special slides. Since approximate alignment has already been attained by surgery, the use of the more flexible amblyoscope is not necessary.

Alternating convergent strabismus is diagnosed when observation shows that the child uses either eye for fixation. Amblyopia does not develop in this type, and treatment consists in refraction followed in six months or more by surgical correction of any remaining deviation. These children have no fusion faculty and orthoptic training is of no value. Because amblyopia does not develop, surgical correction may be delayed until the deviation can be accurately measured by means of the cover test. The squint should be corrected before the child starts to school in order to avoid the effect which the "crossed eyes" may have on his personality.

DIVERGENT SQUINT

Etiology: This is not as clear as that of convergent strabismus. Myopia is a factor in many cases. Little accommodation is necessary for close work, and convergence is not sufficiently stimulated to keep the eyes in alignment. Fusion may be defective or completely absent. Anisometropia is a factor, and when uncorrected may result in amblyopia.

Clinical signs: Most divergent squint develops much later in life than convergent type. This is true of the large group of cases which are secondary to myopia. These usually do not develop until the child has started to school. Amblyopia is relatively rare because most cases are alternating in type and the squint develops late, after the maculae of the eyes is well developed. Many patients squint intermittently and can align the eyes by a voluntary effort of convergence. Some are able to converge for near vision, but are unable to keep the eyes in alignment when fixing a distant object.

Diagnosis: The cover test makes the diagnosis; the covered eye moving toward the nose when the cover is transferred to the other eye.

Treatment: Full correction of myopic errors should be done first. This will often correct a divergent squint of low degree. Surgery is usually necessary in the higher deviations. Bilateral resection of the internal recti or bilateral recession of the lateral recti may be done. Resection and recession of the internal and external recti of the squinting eye is the best procedure in the monocular type. Preoperative and postoperative orthoptic training may be tried, but is seldom beneficial to the extent of obtaining binocular vision.

SUMMARY

1. A great amount of ocular disability is due to amblyopia secondary to squint, almost all preventable.

2. A brief outline of concomitant squint has been presented and an effort made to emphasize the importance of early diagnosis, early treatment, and early surgery in the treatment of monocular squint.



Sight Saving Class

Courtesy of Indiana State Department of Public Welfare

SORE EYES

H. BROOKS SMITH, M.D.*

BLUFFTON

I have entitled this paper "sore eyes" because that it just what I wish to write about. I want to discuss a few local conditions of the eyes and lids which are seen by the general practitioners and in which the patient's chief complaint is soreness and pain. I want to call attention to these conditions, describe the disease and the pitfalls in diagnosis, and touch upon the newer treatment.

The most common eye condition for which a patient seeks the doctor's help is "foreign body in the eye." The type of foreign body seen will vary with the community. In the large cities most of these cases will be industrial injuries, and will gravitate to the ophthalmologist. No mention of these cases is necessary. In the country and small towns the family doctor must handle these cases. The patient usually presents himself with a red, tearful eye, saying that something is scratching and hurting. The patient must be calmed so that the blepharospasm which clamps the lids will be relieved, and then the eye can be examined. It is always well to place a drop of 2 per cent butyn or 1 per cent pontocaine in the conjunctival sac before any attempt is made to examine the eyes. With a good light from a window or an artificial light (and I recommend an electric bulb with a condenser lens, for its light is always uniform and of the same color) the lids should be parted and the eye examined. Emery, metal chips, sand, and particles entering the eye by force will usually be found stuck to the cornea. Dust particles, saw dust, and bugs will be found under the upper lid, and this lid must always be everted for study. Do not wipe or attempt to wipe off a foreign body from the eyeball. Find it, deaden the eye, and then delicately remove it. A foreign body which is not stuck tightly can be lifted off with a blunt spud; a foreign body stuck to the cornea or imbedded in the cornea must be lifted out by getting under it with a sharp pointed instrument, such as a cataract knife. I can not recommend a well-used cataract knife too highly for such a job; improperly used it is a dangerous instrument, but no man should attempt to dig on a patient's eye unless he feels competent to do so and knows the dangers. Emery must be completely removed, and it is the worst offender of the foreign bodies. Farmers all over Indiana often grind tools on motor-driven emery wheels without wearing goggles. Dozens of them make repeated visits to the doctor's office because the emery and pigment ring beneath was not all removed at the time of the first visit. See what you are doing—use a loupe magnifier if necessary; get the eye well anesthetized, and delicately dig out the offending foreign body. When the foreign body is out, irrigate the conjunctival sac with warm boric solution, merthiolate solution, or 1:2500 metaphen. White's or butyn and metaphen ointment should be applied and the eye patched. As an ophthalmologist I have found that most foreign-body cases which have been referred to me, because they were not doing well, were those in which the doctor did not see what he was trying to do and had scuffed up the cornea, leaving the foreign body, or did not tell the patient that a pit in the cornea will continue to hurt until the cornea heals.

A case in point recently came to me following an explosion of a gas heater. The patient suffered minor singeing of the lashes and brows, and had some soot in each eye. He was taken to the doctor who shot each eye full of atropine ointment and ordered the patient to the hospital. Two hours later the patient was lead into my examining room crying because of pain in his eyes. Squeezing of the eyelids was intense. A hasty examination showed both eyes plastered with soot and ashes. The pupils were dilated ad maximum! A drop of 4 per cent cocaine in each eye made him comfortable. Then under good illumination the soot and dirt were easily removed by irrigation with warm saline solution. Staining of the cornea revealed only very minor scratches. Pontocaine ointment was applied, and the patient reported back to work within twenty-four hours, entirely comfortable. His work was close; his accommodation was paralyzed; and he could not go to work for six days because he could not see. Had the first doctor washed the dirt from the eyes and omitted the atropine, the patient could have gone to work five days sooner. Do not use atropine in foreign-body cases! Foreign-body cases needing atropine belong in the oculist's care. Along with foreign bodies we should consider acid and alkali burns of the eye. Acid cases consist chiefly of sulfuric acid splattered from batteries. Irrigating the eye copiously with water at home and then with soda water in the doctor's office, with the application of a bland ointment (White's) is nearly always the most satisfactory treatment.

Alkali burns are by far the worse; they are treacherous things, and they progress to deeper and deeper burns until all the alkali is removed or neutralized. As with acid, drenching the eye with enormous quantities of water instantly is far better than getting the patient into a car and driving seventy-five miles per hour to see a doctor. When the patient does get to a doctor, his eye, which is then most painful, must be anesthetized with either butyn, pontocaine, or cocaine—it makes little difference which, but get it dead. Get the lids open and remove the lime or lye particles stuck to the under-

* From the Caylor-Nickel Clinic, Bluffton, Indiana.

side of the upper lid. Get the eye clean with either a swab, pick, or forceps. Stain the eyeball with 2 per cent mercurochrome or fluorescein. Burns of the cornea and lids which approximate will usually adhere. This patient must see an oculist quickly for the insertion of a plastic conformer. Eyes of this type which are reached in the first two hours and so treated can almost always be saved. If staining shows only a superficial and slight burn, an acid drop such as acetic acid 1 per cent, or for quick lime, ammonium tartrate 5 per cent solution dropped into the eye every ten minutes for a few hours will permit healing. Do not treat alkali burns lightly. Treat them vigorously and watch them. Call the oculist if in doubt.

There are many minor afflictions of the lids which the general doctor can handle safely. Blepharitis is a term used to describe an inflammatory condition of the lids. The symptoms are photophobia, lacrimation, itching, and redness. The conjunctiva of the eyeball is usually red, and there are often tiny corneal ulcers.

The condition is chronic, usually appearing in both eyes; and while it occurs most often in debilitated persons or those on a deficient diet, it also occurs frequently in otherwise healthy persons. A staphylococcic infection of the lash follicles is the bacterial factor. There may be a few of these cases with an allergic background where cosmetics or drugs are at fault, but here the primary disease is a dermatitis of the lids with the lash follicles involved by rubbing bacteria into the lids from scratching.

Most of these cases respond well to 2 per cent yellow oxide, 3 per cent ammoniated mercury, 5 per cent sulfathiazole, or 10 per cent boric ointment massaged into the lids twice daily after ten minutes' application of hot compresses. The hot compresses should be made with plain hot water and not epsom-salts water, as the neighbors will advise. Treatment must be kept going for several weeks to avoid a relapse. Stubborn cases may require the ointments to be alternated, using one a few days and then changing to another. In my hands penicillin ointment has been disappointing. I know that I have made more eyes worse by producing a dermatitis with penicillin ointment than I have cured by relieving the blepharitis. I believe that persistence is the answer to a cure. Improvement in hygiene and attention to general health must not be overlocked.

Concretions of lime salts in the meibomian glands or lying loose just under the palpebral conjunctiva are a frequent cause of red, sore eyes in older people. The treatment consists of surgical removal of the offending body. Two per cent butyn, 2 per cent cocaine, or 1 per cent pontocaine gives a satisfactory anesthesia, and the region of the concretion should be grasped in the everted lid by a chalazion clamp. A delicate incision releases the lime, and no sutures are necessary. Metaphen or White's ointment should be used for two or three days.

Infections of the conjunctiva produce pain, soreness, redness, and lacrimation, according to their severity. Catarrhal conjunctivitis, or pink eye, is the condition most frequently seen. Several types of organism cause the condition, none of which the average medical man is equipped to determine. These organisms are the pneumococcus, the Koch-Weeks bacillus, streptococcus, and the influenza bacillus.

Treatment should consist of iced compresses, unless the cornea becomes involved, and frequent irrigation of the eyes with normal saline to remove the secretions, followed by 1:1000 merthiolate or 1:2500 metaphen. One per cent optochin hydrochloride is indicated as drops every two hours if the organism is proved to be pneumococcus. Stubborn cases require painting of the lid conjunctiva with 2 per cent silver nitrate at two-day intervals for two or three times. Phemerol solution 1:2000 is a good drop to use every three hours for a week following subsidence of acute symptoms. Cleanliness and evacuation of secretions are the most important in the treatment.

Gonorrheal conjunctivitis is diagnosed by finding the organism in early smears and by considering the severity of the reaction in the conjunctiva. Its treatment is standardized. Trachoma has been very rare in Indiana in recent years, and it is not nearly the dread disease it once was. Any suspected cases should be referred at once to an ophthalmologist.

Corneal ulcer is another common condition causing pain, redness, and sore eyes. The diagnosis is simple. A drop of fluorescein should be placed in the eye and then washed out with warm saline until no green color continues to wash from the eye. If the cornea is now studied with a condensed light, focused on its respective areas, any ulceration or break in the cornea will show as a bright green spot. A tiny ulcer may safely be treated for a few days with antiseptics and anesthetic ointments. If it does not heal readily the patient should immediately be sent to an opthalmologist, who can study the cornea under the corneal microscope, watch its progress, and know when to use the more vigorous treatments, such as fever therapy, ultra violet, actual cautery, x-ray, and a host of aids that are frequently necessary to start the repair process. Of all eye diseases corneal ulcers can be the most treacherous, the most time-consuming, and the most unresponsive to treatment. After all, the doctor can only help to remove the obstructions from the body's reparative course. The patient heals—not the doctor; we can only guide the patient and help him promote healing.

It has been my purpose here to enumerate some of the common conditions which cause sore eyes. I have attempted to outline recognized treatment which the general practitioner can carry out. I have mentioned some pitfalls and have tried to point out the case that will get well under his care, and the one which he should refer to the oculist so that his worries may cease and the oculist's may begin.

SOME PROBLEMS OF LIGHTING*

C. A. ROBISON, M.D.
FRANKFORT

With the popular acceptance of fluorescent lighting and its rapid growth in usage in the past five years have come many reports of seeing-discomforts which have been attributed to the light itself.

During this time many cases have been seen in our office. Some of them have been referred to us by optometrists and men in general practice because of extreme headaches while working under fluorescent lights.

For this investigation I contacted five sources for my information: The American Medical Association, the General Electric Company, the Westinghouse Electric Company, the Bausch & Lomb Optical Company, and the American Optical Company.

In order to properly convey my information to you, it is necessary to explain first what is good lighting practice; second, light and lighting.

Good lighting practice assumes a suitable general level of illumination augmented by local, increased light on the specific job. A further assumption is that this illumination will be well dispersed, with no high or low levels caused by too wide a spacing of lighting units. Likewise, units will be placed well above the normal field of view, and will be so baffled or louvered as to prevent excessive brightness in the field of view. Excessive ceiling brightness will be avoided. Under these conditions, and with judicious use of paint to improve contrast where possible, seeing is improved and made easier.

Unfortunately, many lighting installations, both incandescent and fluorescent, fail to meet such requirements. Exposed or improperly-shaded or louvered bulbs create excessive brightness within the field of view and result in photophobia.

Excessive brightness produced by glare within the field of view results in "veiling haze" and visual discomfort. This glare may be present even with the most carefully-designed lighting system if the work surfaces are highly reflective and disposed at many angles to defeat the carefully-planned distribution of light. Witness to this is the airplane fabrication plant with its many large highly-reflecting metal surfaces. Specular reflection from these surfaces produces glare-points that cannot be focused to form an image on the retina if the eye is adjusted for the working distance; hence, form a veiling haze that confuses details of the work image and produces discomfort.

Color of light, in addition to diffuseness and the direction at which it falls on the work, is also an important factor in glare consideration. Glare may be noticed at lower intensities with incandescent illumination than with daylight, because Mazda light is predominantly yellow-orange in addition to being less diffuse. Yellow light produces glare at lower intensities than does daylight. This Mazda light, however, with its excesses in yellow and orange, is not so fatiguing to the eye as are light sources, such as fluorescent installation, that produce in the blues and greens. The common blue-bulb daylight lamp, designed to correct the excesses of yellow-orange of the regular white incandescent lamp might be mentioned as such a source. But even if glare of any cause, and unusual brightness within the field of view, be eliminated, too high levels of illumination will, after a period of time, prove uncomfortable.

To recapitulate, glare and its accompanying discomfort may be anticipated at lower intensity levels with incandescent light than with white light. Light that predominates in the blues and greens tends to be more fatiguing than Mazda light. Too high levels of illumination are fatiguing. (There is a wide variation among persons as to what constitutes excessive illumination.)

Doctor Luckiesh, director of lighting research for the General Electric Company, has the following to say in regard to light and lighting:

"In order to be able properly to appraise the light and lighting from fluorescent Mazda lamps, one must fully realize that there is nothing peculiar about the radiant energy emitted by the lamps or their brightness or the brightness of the surroundings. All these factors can be readily measured and analyzed by appropriate instruments and techniques. The light from white and daylight Mazda F lamps is closer to daylight in color than the light from tungsten-filament lamps. Obviously, this is desirable from the viewpoint of appearance of colored objects, and also from the viewpoint of mixing with natural daylight. Thus, the common annoyance of the yellowish light from tungsten-filament lamps, particularly in the daytime, is greatly reduced. This is an additional favorable factor.

"Light or visible radiant energy emitted by common light-sources is accompanied by invisible ultraviolet and infra-red radiant energy. The invisible energy contributes nothing toward seeing, and a primary object of light-production is to produce as much light as possible with a minimum of invisible energy. The infra-red energy produces no known physiological effects excepting those due to heating. The ultraviolet energy produces various effects, depending upon the wave length. For example, it kills germs and prevents and cures rickets. In excessive quantities it produces erythema of the skin and conjunctivitis of the outer

* President's Address presented before the twenty-ninth annual meeting of the Indiana Academy of Ophthalmology and Otolaryngology, at Indianapolis, on April 10, 1946.

membranes of the eye. Sunlight is a universal example of such an illuminant. The ultraviolet energy emitted by artificial light-sources is easily controlled by the composition of the glass bulbs or by other enclosing media. It does not matter whether the light-source is a glowing filament or a mercury arc. The short-wave limit of ultraviolet energy, as well as the output of such energy, can be readily confined within safe limits.

"It is axiomatic that any of our artificial light-sources to be used for lighting purposes should emit their energy entirely within the wave length range of the spectrum of sunlight. It is equally axiomatic that normal human eyes are adequately adapted to radiant energy of all wave lengths present in sunlight outdoors. Of course, excessive quantities of radiant energy are destructive, but long ago we have learned not to look directly at the sun for any appreciable period. Before our fluorescent Mazda lamps were made available commercially, it was made certain that no appreciable ultraviolet energy of wave lengths shorter than the short-wave limit of the solar spectrum is transmitted by the glass tubes of these lamps. Therefore, normal human eyes should not be harmed by the light from these lamps.

"Obviously, there is always the possibility that some eyes, due to a pathological condition, might be adversely affected. We know of no such cases, but if they are found it should be equally certain that they would be adversely affected by similar exposures to sunlight outdoors, or even to skylight which is scattered sunlight outdoors during the winter months, for example, and temporarily sensitive to ultraviolet energy, just as the skin is particularly sensitive in the spring. However, if there are such cases they should become quickly adapted to the ultraviolet energy, just as the skin is.

"The cyclic flicker of fluorescent lamps is not a desirable feature, but it is not without precedent on a large scale. For example, large communities for many years have been exposed to the twenty-five cycle flicker of tungsten-filament lamps without any general deleterious effect having been detected by eyesight specialists or physicians. The flicker from one fluorescent lamp operating on sixty-cycle electric service is of the same order as that from a twenty-five watt tungsten-filament lamp operating on a twenty-five cycle electric service. When two fluorescent lamps are connected to the two-lamp ballast the flicker is so greatly reduced that the stroboscopic effect produced by rapidly-moving bright objects is scarcely noticeable, if at all.

"We have studied ease of reading under light from tungsten-filament and fluorescent daylight lamps, respectively, by means of our very sensitive criterion, the rate of blinking. We found no differences for the same level of illumination and the same reading task, notwithstanding the fact that by means of this criterion we have studied and detected the effect of many factors in seeing. This work was done with the maximum flicker of the fluorescent lamps.

"Many years ago there was some suspicion that the relatively great amount of infra-red radiant energy which accompanied the light from tungsten-filament lamps, compared with that in natural daylight, might be a cause of eyestrain or eye-fatigue. This suspicion was not proved to be justified. Therefore, it is far less tenable for fluorescent Mazda lamps, because the radiant energy per foot-candle from these lamps is much less than from tungsten-filament lamps. In fact, it is now quite comparable with that from natural sunlight and skylight. Mazda F lamps supply the "coolest" foot-candles ever available from artificial light-sources for general use.

"With the foregoing brief comments about the light and radiant energy emitted by Mazda F lamps, let us briefly consider the factor of lighting. Visibility and comfort are affected by the distribution of brightness in the visual field. The relatively low brightness of fluorescent Mazda lamps is immediately an advantage over other artificial light-sources. These brightnesses are comparable with that of the sky as seen through a window, and are only one-third or one-fourth as great as the brightness of a sunlight cloud. An inside-frosted tungsten-filament lamp, such as is commonly used in decorative fixtures in the home, is ten to twenty times brighter. Therefore, Mazda F lamps are far less likely to produce eyestrain and eye-fatigue as a result of their brightness than tungsten-filament lamps. However, even with this low brightness, better seeing conditions are produced if the light-sources are screened from the normal visual field.

"The relatively low brightness of Mazda F lamps makes it practicable to use lighting systems which supply a powerful downward or direct component of light. This makes it possible to use these efficient light-sources even more effectively. However, an upward component, or one supplying light to the general surroundings, is also desirable for comfortable seeing conditions. Glare reduces visibility and produces eyestrain and discomfort. It is conspicuously produced by bare light-sources or by their images reflected from glossy or polished surfaces. It is obvious that sources of low brightness, such as Mazda F lamps, are insurance against the excessive glare of much brighter light-sources when they are used carelessly, as is too commonly true, or when large direct components of light are used.

"Good seeing conditions produce high visibility of the visual task and result in easier seeing. Fluorescent Mazda lamps possess more inherent desirable features for providing the conditions for easy seeing than any of their predecessors. This is the primary justification for a new illuminant, and a new light source. Tungsten-filament lamps are relatively small in physical size, for the same wattage and the high brightness of the filament has a great advantage in controlling light for special purposes. These lamps provide a variety

of wattages over a large range and of physical sizes that are practicable. Fluorescent lamps have limitations in these respects, and may be considered partly complementary to filament lamps.

"Artificial lighting is doubly rich in having these two radically-different light-sources available. However, for general lighting practices Mazda F lamps represent great advances in many large fields of light. The light is safe for the eyes. Color and spectral character are under control. The white and daylight lamps provide light which mixes well with natural daylight. The luminous efficiencies are relatively high, and the foot-candles are relatively cool. Their brightness represent large steps toward the ideal in safety and comfort. As the novelty wears off, unfounded suspicions are diminishing. Eventually they will entirely disappear. Looking backward, these new lamps represent a very great achievement in light-production. Looking forward, they are already fundamentally forward; they are already fundamentally challenging natural daylight as an illuminant."

W. H. Kahler, lighting engineer for Westinghouse Electric Company, had this to say in regard to the advantages and disadvantages of fluorescent lighting:

"Advantages commonly claimed for fluorescent lighting are: (1) high efficiency; (2) low brightness; (3) extended shape; (4) cool light; and (5) excellent color.

"Each of these factors represents a true advantage if properly interpreted. Lighting is a science. To be correctly applied it must be skillfully prescribed for each application. Lighting authorities have known this fact for many years.

"(1) *High Efficiency*

"When only filament lighting was available, illumination levels of twenty to thirty foot-candles were in the upper bracket of high-quality general illumination. Thirty foot-candles required about six watts per square foot for indirect lighting, and about four watts per square foot for diffused direct lighting. For many seeing tasks lighting engineers have realized that fifty foot-candles or more should be supplied for best seeing. With fluorescent lighting fifty foot-candles require about four watts per square foot for semi-indirect light, and about three watts for diffused direct lighting.

"(2) *Low Brightness*

"Lighting quality really means proper control of brightness. Foot-candles are merely a measure of lighting quantity. Quality is just as important as quantity, however, but is far more difficult to measure and appraise. Glare, the worst offender to quality, is caused by:

"An improperly-shielded lamp (filament, mercury, or fluorescent) in the line of view. It causes direct glare.

"Large areas of relatively low brightness in direct view, such as a large expanse of white wall or an unshaded glass block wall.

"Severe brightness contrasts, such as a direct luminaire view against a dark or unlighted ceiling.

"The brightness of a fluorescent lamp is considerably less than that of a filament lamp. This does not mean, however, that a bare fluorescent light will not cause glare. On the contrary, an exposed fluorescent lamp in the visual field is the source of extreme glare. Therefore, such lamps must be well shielded by a reflector, louvers, or some diffusing medium.

"This rule has been disregarded in many fixtures and installation designs. As a result, users have often condemned fluorescent lighting, rather than its incorrect application."

The Technical Advisory Service of the Smaller War Plants Corporation, in an effort to aid the small business man, wrote to the American Medical Association in part as follows:

"From people who work in a sitting or fixed position, such as in offices and drafting rooms, complaints of eye-fatigue from fluorescent lighting are fairly common. The tube is bright and also dark one hundred twenty times a second. This speed 'fools the eye,' so that the tube has the appearance of burning (being bright) all the time. Does this speed also 'fool the nerves' leading to the eye, or are they fast enough to sense this dark and bright effect and try to make adjustments for it?"

In reply to this inquiry *The Journal of the American Medical Association* had the following to say:

"Fluorescent tubes require alternating current. Alternating current is usually sixty cycles, sometimes twenty-five cycles per second. Each time the current changes its direction there is an infinitesimal pause when no current is flowing. The duration of the pause is a small part of the cycle and is not long enough for the lamp to cool off and become dark. It merely becomes a little less light. When plotted as a curve it is not a straight but a wavy line (a sine curve). It is gross exaggeration to speak of this as being 'bright and also dark one hundred twenty times a second,' when really it is bright and slightly less bright—not dark. The lowest part of each wave is far above the abscissa, which is zero or darkness. How the eye reacts to this type of illumination depends on what it is looking at. Looking at a small area such as a book on the desk or a picture projected on a screen, the sensation produced by a very short exposure persists for an appreciable time. If the images are projected as in ordinary amateur motion picture projectors, sixteen per second, the pause between two successive images is so short that the sensation persists from one to the next, and no flicker may be noticed. With the professional projectors the speed is about twenty-five or more per second, and there is still less flicker. This presupposes that the successive images fall on the same area of the retina.

"If they do not, then an entirely different effect is produced. The successive images fall on a series

of different areas of the retina, and each area will give its separate sensation. Each will persist long after the next is initiated, and so a string of separate images is seen. If the object is a small light, a string of lights is seen. This can happen when the object moves rapidly across the field of vision, or it can happen when the object is stationary, but the eye moves its visual line across the field of fixation. In either case the successive images will stimulate not only the same area of the retina, but a series of areas whose separation will depend on the speed of the movement.

"The way it works out in practice is this: when the work to be done involves little extensive movement, as is the case in reading or writing, no flicker is noticed; but if there is rapidly-moving machinery or the like, the movement will not be smooth and continuous, but jerky, in rapid steps; or if the work involves shifting the gaze rapidly from one part of the field to another, there may be an annoying, jerky, flicker sensation. This is readily demonstrated with light pulsation even as rapidly as two hundred and fifty or more times per second, with which absolutely no flicker would be observed in steady looking because the images would fall on the same area of the retina.

"There is a very effective way to eliminate all stroboscopic or flicker effect with fluorescent tubes, making them far steadier than any other light on alternating current, and that is by combining the tubes in pairs, so coupled that the maximum of one tube corresponds with the minimum of the other, thus compensating for the flicker. These tubes have been in use for some years, and are very satisfactory."

The Bausch and Lomb and the American Optical Companies stated that their research departments had nothing definite to report upon fluorescent lights or lighting at this time, but recommended the use of glare-filtering lenses until further research of the subject can be made in the postwar period.

From the reports which have been given, I now submit the following opinions:

(1) The ultraviolet energy from clear-blue summer skylight is three to four times as great per foot-candle as fluorescent light.

(2) Light from fluorescent lamps resembles daylight more closely than that from tungsten-filament lamps. This color resemblance to daylight is a desirable quality.

(3) Infra-red energy found in fluorescent lighting as now manufactured produces no known physiologic effect except that due to heating. Fluorescent light generates less heat per candlepower than tungsten lamps.

(4) Glare occurs in any system of lighting. Its solution rests with illuminating engineers.

(5) Individual differences occur in the level of illumination (foot-candles) required to provide a satisfactory degree of visual efficiency and eye comfort. Twenty foot-candles is essential for such critical tasks as reading. Higher levels of illumination are desirable for prolonged seeing, for discrimination of fine details, and where low contrast prevails. These standards can be readily maintained in working places through the use of properly-installed fluorescent lighting.

(6) Excessive light may produce symptoms of eyestrain in susceptible individuals regardless of source. Constitutional factors should be corrected as well as the amount and kind of light.

(7) Noticeable flicker is largely eliminated in modern fluorescent installations.

(8) Fluorescent light is not harmful to vision. It should not cause eyestrain if properly installed and used.

AN ARGUMENT FOR PREVENTION

Glen H. Harrison *(Tr. Amer. Acad. Ophth. and Otolaryng.,* May-June, 1945) stated that 80,000 persons in the United States are blind in one eye and 8,000 in both eyes, as a result of industrial accidents, and that of 1,000 eye accidents daily, all but 20 might have been prevented.

OCULO-GLANDULAR TULAREMIA

This disease is diagnosed with confidence by a positive agglutination reaction. Antitularense serum has value when given in early stages. Streptomycin has been reported superior to either penicillin or sulfonamides. Bismuth sodium tartrate given intravenously showed favorable results in 61 cases.

THE WHITE CANE, THE SEEING-EYE DOG, AND—RADAR?

Van Dellen in the "How to Keep Well" column of the *Chicago Tribune,* February 15, 1946, notes that experiments are being made with a small device to be worn by the blind. It projects a beam of light, which, striking an obstacle directly ahead and within 20 feet, is reflected back to a photoelectric cell; the energy so generated is transformed into sound that becomes audible by a hearing aid.

He quoted Brewster, who studied the case histories of 700 blind persons and concluded that sight could have been preserved in 73 per cent of them.

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MAY, 1946

Editorials

CONSERVATION OF VISION AND PREVENTION OF BLINDNESS

This is the seventh consecutive annual issue of THE JOURNAL that has been devoted, almost exclusively, to the important subject of the "Conservation of Vision." For many years ophthalmologists throughout the country have been spending much time and energy in promoting, by various means, methods for the Conservation of Vision and the Prevention of Blindness. This work has been pioneered and carried on not only by such national organizations as the National Society for the Prevention of Blindness, the American Academy of Ophthalmology and Otolaryngology, as well as others, but also by the various state committees on Conservation of Vision.

The excellent work done by these various organizations, and the gratifying results achieved, have been accomplished only by intensive and persistent effort by their respective members. An educational program for the layman has been in progress for many years; this consists of lectures and informal talks, by eye physicians who are qualified for the purpose, before various organizations and other lay groups, such as the Parent Teacher's Associations and the like, in an effort to inform and to impress upon the layman the importance of correct care of the eyes. In addition, carefully-prepared articles, in language easily understood by the reader, dealing with the function and care of the eyes, as well as diseases and complications which may occur from improper care or neglect, appear at frequent intervals in the popular periodicals and the press. That these articles are read, there can be no doubt, judging from the numerous specific questions relating to certain eye problems which the patient asks the eye physician.

It is largely through the efforts of the ophthalmologists that the number of accidents and eye injuries occurring in industry has been reduced greatly in the past ten years. This has been accomplished by improvement in lighting conditions—adequate illumination for the particular task; insistence on specific visual standards for certain types of work; and the protection of the eyes of workers, by means of goggles, when engaged in hazardous occupations.

The establishment of glaucoma clinics for the treatment of patients afflicted with this disease, and orthoptic training centers for the correction of fusional difficulties and faulty reading habits so frequently occurring in youngsters, are more recent developments in the Conservation of Vision and Prevention of Blindness Program. The glaucoma clinics have been the means of preserving useful vision in countless persons who otherwise would have become blind had it not been for their existence. The orthoptic clinics have been most successful in the results obtained by systematic training of children with amblyopia and faulty co-ordination of the eyes.

While great strides have been made by the Committees on the Conservation of Vision, which are most commendable and deserving of the highest praise, there still remains much to be accomplished in the field of education, reduction of eye hazards, and the early recognition and appropriate treatment of diseases of the eye.

The articles appearing in this issue of THE JOURNAL have been prepared by ophthalmologists who are competent to write on their respective subjects. The articles are exceedingly practical, as well as informative, and should be read by every practicing physician.

HAVE YOU MADE YOUR RESERVATIONS ?

A.M.A. Meeting, July 1-5, 1946
at San Francisco

Annual Session of the
Indiana State Medical Association
October 29, 30, and 31, 1946

N. K. FORSTER, ASSOCIATE EDITOR

At the recent French Lick session, the Council of the Indiana State Medical Association, taking into consideration the fact that the editor of THE JOURNAL was adding years to his age, and after thirteen years of service had reached the period when he needed some help, voted to ask the editor to name an associate editor; to take his time about it, and to report at a later meeting of the Council.

After due consideration of this important matter, and after having consulted many officials and members of the association, we made the recommendation at the Council meeting of April fourteenth that Dr. Neslen K. Forster, who recently retired from the presidency of the Indiana State Medical Association, be named to this post. This recommendation was duly approved by the Council.

Dr. Forster, of course, is well known to Indiana Medicine; he comes to the staff of THE JOURNAL with editorial ability. For some years he served as editor of the *Lake County Medical News*, and has contributed numerous articles, both to THE JOURNAL and to other medical publications throughout the country. He is a versatile writer, keeps abreast of medical literature, and continues to be a good student. With his years of service in his local society, several years as a member of the Council of the Indiana State Medical Association, and his year as president he is intimately familiar with association matters.

We are highly pleased to have Doctor Forster as our associate editor, and believe that our having named him to this post will meet with the approval of our entire membership.

"TOMMY" HENDRICKS MOVES UP

Some twenty years ago a special association committee was appointed to stage a hunt; it was to be a real hunt, for BIG game. This committee had been given plenty of instructions before setting out in quest of their quarry; hence, knew just what they were after. They were ordered to bring in the best young man available in all Indiana, or elsewhere, to serve as the first full-time executive secretary of the Indiana State Medical Association. When we looked over the specifications we were mighty glad that we were not a member of this committee; it had a man-size job before it.

But the committee soon went to work, their first action being what we now know as the "screening" process, sifting out a lot of chaff before setting down to a serious consideration of the problem before them.

And, they came up with the *real* answer to the "sixty-four dollar question," with a blue-eyed, blonde, newspaper chap, late of the *Indianapolis News*. Well do we recall Tommy's entry into his new field; not at all cocky about what he was getting into—in fact, rather of the eagey type. The first thing he said, was, "I want a place to work; I want a lot of room, so I can spread myself," and he has been spreading ever since.

With a good newspaper background, where he did a lot of "feature" stories, he was able to meet people well, and in no time was as popular in the association circles as he had been in the newspaper field. He began to get about the state, and in a short time there were calls for his visits from every county medical group—thus giving him a wide, personal acquaintance right from the start.

And when a few months later the "Grand Old Man of Indiana Medicine," the late and revered Dr. William Niles Wishard, Sr., remarked, "I am satisfied that we have *the* man for the job, we felt that Tommy would make good, for Doctor Wishard was a rare judge of human character.

Tommy has been with us through these past twenty-two years, doing his daily stint, planning for the morrow, "selling" Hoosier Medicine as it never had been sold, all the while making friends in the medical profession throughout the whole country. He was in demand as a speaker at state medical meetings in many sections, and in due time even "crashed" 535 North Dearborn Street, where an austere group held forth.

It would be unfair to ask anyone to try to specify the most outstanding accomplishment made by Tommy Hendricks through all these years. They have been many, and they all have been worth while. His work during the war years is a monument to him—one that will go down in Hoosier medical history.

He was drafted to help out in the enormous job of the Procurement and Assignment Service, whose program was lagging. He had an official title so long that we never were able to remember it all, so it suffices to say that he was the official consultant to this board. Our association "loaned" him half-time for this work, and about half of his time was spent in Washington and throughout the country, engaged in the vitally-important job of providing medical services for the Army and the Navy.

About the time this work was pretty well completed his services again were requisitioned, this time by the American Medical Association, which needed the best man in the country for one of the biggest jobs on its hands—it could be best defined as "Public Relations." A council had been formed, and they wanted a man to head it, so Tommy was named secretary of the council.

After some months it was found that this was no longer a half-time job. It was a job that called for action every day in the year, so naturally Tommy was named to the post, and as of May 1, 1946, he becomes a fixture at American Medical Association headquarters.

But Tommy, Hoosier born, will not leave Indiana; says he, "I just can't get this Hoosier stuff out of my system," so he and Peggy and "Cece" will take up their official residence at Culver (Lake Maxinkuckee to you) where they have had their summer home for many years. They will spend

something like eight months of the year there, and the balance of the time in Chicago. Their lake home is a most delightful place, but the latch string will not always be out, this for the simple reason that there is no latch string about the place. So if you are driving along the east shore of the lake and see a huge mail box marked, "Thos. A. Hendricks," just pull in, walk right through the kitchen, and call "Hi" and we'll bet you get a hearty welcome—we know, we've tried it on more than one occasion.

Much more might be written about "Blue Eyes," as one of his Indianapolis newspaper friends once named him, but his work in our behalf is well known to every Indiana physician; his record of achievement forms a part of the history of the livest state medical organization in the country.

Ray E. Smith, who has for some time served as assistant executive secretary, will take over, and with his background of public life, plus a natural adaptability to get things done, we are assured that things will go on in good order. Like Tommy, Ray also had been bitten by the political bug a long time ago, and has had his fling at Hoosier politics, fairly recently completing a term as secretary to Former Governor Schricker. He also has a newspaper background, and is an organizer of the first water. During the time he has been with us he has taken things in regular stride; at first keeping his eyes open, watching everything that went on, and saying little. That is one of the things we first admired about Ray Smith—his ability to sit and listen until he knew what it was all about.

So Hoosier Medicine will keep on progressing; meeting every contingency that may arise; solving its problems in short order, and thus keeping right at the top.

In conclusion, we can but quote the Hoosier Poet, paraphrasing his comment a bit, "Good-Bye, Tommy; take keer of yourse'f!"

OLIN WEST RETIRES

After a service of more than two decades as Secretary-General Manager of the American Medical Association, Dr. Olin West has announced his retirement. He is being succeeded by Dr. George F. Lull, recently retired from the United States Army Medical Corps, with the rank of Major General. This change took place as of April first.

In his long years of service at the A.M.A. headquarters, 535 North Dearborn Street, Chicago, Doctor West was known to the medical profession throughout the country, as well as in many foreign countries. Prior to coming to Chicago he had served as secretary-editor for his home state medical organization, with headquarters at Nashville, Tennessee.

We have known Doctor West through most of these years, and since 1933, when we became editor of THE JOURNAL, have had many occasions to consult with him on matters concerning our work. We always had found him affable and ready to do anything within his power to help us with our problems, and in recent years in connection with the Cooperative Medical Advertising Bureau we had more frequent contacts.

Olin West has done a good job, and it is with regret that we see him go, but the years have taken their toll, and this man deserves the well-earned rest which will be his from now on. We have not always agreed with his A.M.A. policies, as is the case with many others who have been active in medical organization work over the country; we at times have called him autocratic, particularly in recent years when health insurance plans were being discussed by every medical group. The "lean, lanky, Tennessee squirrel shooter" had his own ideas about these things, and, as those who know the man will agree, had his own manner of making such ideas known.

He was a good organizer, knew all the "ins" and "outs" of the headquarters' building; knew most of the employees, personally; and could give, off hand, details concerning most any phase of the operations there.

THE JOURNAL adds to the many encomiums now being offered to him, and trusts that his retirement will bring about a complete restoration of health, and that for many years to come we may have the benefit of his sound advice.

To his successor, George Lull, we extend every good wish for a successful administration. He has a proper background as an organizer; is a firm beliver in medical organization; and, judging from a recent meeting with him, we believe that he "wants to know." By that we mean he is entering on a new undertaking far different from his assignment to the office of the Surgeon General of the United States Army—in recent years he was Assistant Surgeon General. Here it is no longer a matter of Army routine; in many things there will be no precedent to follow—decisions must be made right now. So that is what we mean by saying, "he wants to know." In speaking to our committee group he remarked that it was new to him; that he wanted our advice—a lot of it, and that he would follow that advice.

So, with the passing of the "Old War Horse," and the entry of a newcomer, we believe that the affairs of the office of Secretary-General Manager continues in good hands.

ANNUAL MEETING
INDIANA STATE
MEDICAL ASSOCIATION
INDIANAPOLIS,
OCTOBER 29, 30 AND 31

FULL-TIME COUNTY HEALTH OFFICERS

Every so often emergencies arise which call for action on the part of health authorities, and each one of these occasions afford cogent arguments in favor of full-time health officers. A case in point is revealed in news-stories in recent Chicago papers concerning a diphtheria epidemic in the North Shore community, just above Chicago.

As we interpret these stories, some sixty cases had been reported in a matter of a few weeks, with some deaths. In some communities quarantine areas were established and measures taken to control the epidemic. The Illinois State Department of Health, which moved in, is quoted as stating that if there had been a full-time county health officer, this calamity could have been averted. And this is all too true!

As we have commonly averred, and is generally known, diphtheria is a preventable disease; therefore, diphtheria is an unnecessary disease. Communities much larger than the North Shore area are not troubled with diphtheria epidemics. They just do not have them, because health authorities, plus the united support of the medical profession, see to it that immunization programs are carried out—not as a sporadic effort, but as one of the everyday tasks of the medical profession.

So, when a prosperous, enlightened community such as the North Shore is stricken with this disease, it is apparent that some one or some groups has been asleep. They have not done the thing that should have been done. Several cities might be cited as examples of what can be done by concerted effort; Gary, in our own state, being a notable one. Here the Medical Department of the Gary Public Schools took over—with the consent of the local medical profession, with the result that today Gary is not much concerned about diphtheria, as an active disease.

In most Indiana cities, and in many of the lesser-populated counties, the same thing has been done, and is now being done. The net result is that in most instances mothers do not need to be advised to have the new baby immunized; she just picks it up, takes it to the office of her family doctor, and the job is done. We personally realize just what a comfort it is not to worry about diphtheria, since our four grandchildren are not likely to acquire the disease. With our own children, it seemed that about every fall we would begin to worry about diphtheria.

We mentioned something about someone slipping up on this thing, along the North Shore; well, in the first place, this community is large enough and is wealthy enough to employ a full-time health officer, the best one that can be found. His first job, so far as diphtheria is concerned, would be that of educating the public in the matter of diphtheria immunization. His next job—rather the two should be combined—would be to unite with the local medical profession in this campaign of education. In months the proper machinery would be put in motion and would roll along without much trouble thereafter.

Of course, the cry is raised, "It costs money to operate a full-time health department." That is perfectly true, but it should be remembered that it also costs money to have a diphtheria epidemic! The economic cost of this present epidemic is, in our judgment, far more than the cost of a going health department, one that is on the job twenty-four hours a day, three hundred and sixty-five days in the year. In addition, there is the freedom from worry; we dare say that the parents in the North Shore areas did more worrying through this period than at any other time in their lives; and it costs money to worry, make no mistake about that!

The scene of this episode was in our neighboring state, but it could happen here. It does happen here, and will happen again and again until we adopt the stop-gap, which is a complete reorganization of our county health units.

We have the perfect setup necessary to bring about this change; a commissioner of Health who is competent, who wants to work, and who knows how to do the job, and a new State Health Council, wholly free from politics, rearin' to do things. The medical profession of Indiana stands ready to do their part of the big job; hence, it would seem that about the only thing lacking is the education of Mr. and Mrs. John Q. Public—a big job, but one that can and must be done.

WAIVER OF DISABILITY

This moot question occupied the attention of many during the earlier days of the recent war, since a great number of medical men, in offering their services, were found to have more or less minor disabilities. In such cases a "waiver" was signed by the enlisting man, and if it later was ascertained that said disability was such as not to interfere with his carrying out his part in wartime activities, he was given an assignment.

There has been much of a controversial nature regarding this matter of waiver, several of our medical journals having discussed it from every angle. Just recently, in the February 21 issue of *The New England Journal of Medicine*, appeared an editorial, which we quote, and a letter from a colonel in the Medical Corps, both of which articles would seem to have a bearing on the question, and to clear it up to a large extent.

The medical officer, whose name is not given, makes it clear that one does not waive anything, even though he signs a waiver. Among other authorities, he quotes from a decision of the United States Supreme Court: "The right to compensation is a statutory right, and as such cannot be waived by a person as a condition of employment by reason of such service in the armed forces."

"In other words," says the Colonel, "a defect existing prior to entry into the service, which becomes aggravated to a disabling degree, by reason of service in the armed forces, is compensable just as though the defect were incurred by reason of such service."

This would seem to place a new light upon a problem that is of interest to many service men, and to answer many of the questions that have been asked about such cases, not only by Medical Corps officers, but by enlisted men, generally.

We quote herewith, in its entirety, the editorial in this issue of *The New England Journal of Medicine*, since it succinctly sums up the whole matter:

"WAIVER OF DISABILITY

"Attention is called to a letter published elsewhere in this issue of the *Journal* in which the commanding officer of an overseas station hospital clarifies a misunderstanding concerning the so-called 'waiver of disability' on the part of an officer entering the armed services of the United States. There can be no doubt that it is generally believed that if a man or woman accepts a commission in the armed services, and at the same time has a physical defect that can serve as a source of future trouble, he expects, as part of the sacrifice he must make for his country, to 'sign a waiver,' which will release the government from all responsibility for the care of conditions subsequently arising out of the disability that has been waived.

"Such a belief seems to be entirely wrong. If the author of the letter is correct—and there is no reason to suppose that he is not—this false belief is based on an equally erroneous misconception. It is the government that does the 'waiving.' By so doing it does not deprive the physically-defective officer of his right to obtain redress for disablement arising in the line of duty even though it may be secondary to his disability. Instead, the government assumes the risk and 'accepts the person in spite of the defect.'

"This is an important point, and one that should be drawn to the attention of all veterans. From conversations heard here and there it is apparent that there is a considerable number of disabled veterans who think that they are not entitled to apply for benefits from the government because they waived their rights to make such application when they entered the service. Veterans' organizations should publicize this mistake so that it can be corrected at once. Such veterans no longer should be deprived of the help that they may need badly and to which they are certainly entitled."

Editorial Notes

As has been customary for several years, the May issue of THE JOURNAL is devoted to Conservation of Vision, and again the Committee on Conservation of Vision has been most helpful in planning this number. We express appreciation to Dr. C. W. Rutherford, chairman, and other members of the committee, and to the respective authors for their assistance in connection with this issue. "Conservation of Vision" and "Prevention of Blindness" are subjects which merit the attention of the specialist and the general practitioner, alike.

The Tennessee State Medical Association recently tendered a testimonial dinner, honoring Harrison H. Shoulders, long-time Secretary-Editor of that organization and recently named as President-Elect of the American Medical Association. Doctor Shoulders also had served for several years as Speaker of the A. M. A. House of Delegates.

It seems that no matter what is attempted, "that Indiana gang" knows just how to do it—and does it. This time we refer to the activity—and it is just that—incident to the setting up of the new Section on General Practice, which was authorized at the recent French Lick session. The committee appointed to this job has been, and is, very active, as will be noted by a communication recently printed in THE JOURNAL. We predict that this will soon become one of the most popular of all our sections, and that as years go by it will be doing things. Another prediction: it will not be long ere we find various "specialists" seeking admission to the new section!

Reports from the West Coast are to the effect that the registration for the annual meeting of the American Medical Association, July 1-5, at San Francisco, will be a record-breaker. Many folk unable to travel during the war period are now planning to make this one great vacation trip, which will also afford the opportunity of attending an annual meeting that will be somewhat historical. It goes without saying that hotel accomodations are being snapped up, and if you have not already made yours, you better look after it. Post-war travel promises to be the greatest in the history of the country, according to transportation officials and some of the touring agencies. Send your requests for train reservation to the headquarters of the Indiana State Medical Association —see page 251.

According to newspaper reports, Indiana is fast becoming hospital-conscious, no less than four counties having programs for the erection of new institutions or for enlarging those already in operation. Down in Monroe County a new wing with thirty-five beds and ten bassinets is nearing completion. An additional wing is being added to the Johnson County Hospital, already under construction, giving a total of a sixty-two-bed capacity. Washington County recently held a referendum in the matter, the vote being twenty-two to one in favor of a new hospital, and the erection thereof will begin as early as possible. In Shelby County the City of Shelbyville Board of Works has voted in favor of an addition to the W. S. Major Hospital there, providing additional wards. These signs of the times are of the progressive sort; they portend just what the American people are thinking about —the matter of health. No community can be said to be up and doing without adequate hospital facilities.

Getting back to the general subject, "Taxes," it will be well to remember that along in the latter part of May you will receive from the Collector of Internal Revenue an application blank for renewal of your narcotic license, together with inventory sheets. These are to be completed and mailed to the Collector not later than June 30. Practically all our members are in the Class 4-5 category, the registration fee being one dollar. We would suggest that this little matter be looked after immediately upon receipt of the little note from the collector, for delay in filing thereof causes a little uneasiness on the part of the delinquent.

As we had predicted, there is already a step-up in the number of appeals for donations to this and that cause. In one week we received three separate "stamp" appeals; those little stickers costing a dollar per sheet. No doubt the folk behind these appeals are aware that the pioneer "stamp" movement has been under way for many years and is a huge success, referring to the Christmas Seals so universally used over the country. Then, too, we are getting the first of the several appeals annually received from "Vacation Camp" people, principally those in the eastern cities. Just why Indiana doctors should be asked to assist New York City programs, for example, is quite beyond our ken. Right here in Indiana we have underprivileged children, and most of the members of the profession are glad to do their bit in assisting these little tykes. Better donate your money to home projects.

We have to thank Joe Adams, the "Rambling 'Round" columnist of the *Indianapolis Star* for setting us straight in the matter of the Kentucky-Indiana boundary line. We long had known that Indiana does not own or control even one small part of the Ohio River, although where a stream forms the boundary line between two states it is customary for each of these states to own the waters up to the middle of said stream.

According to Joe's story, it all came about when in 1787 Virginia ceded to the United States what was then known as the Northwest Territory, Kentucky then being a part of Virginia. Among other conditions, Virginia was to retain title to the river to the low-water mark on the north side of the stream—the Indiana side.

Accordingly, Kentucky, when it became a state, maintained control of all fishing and the sand and gravel rights of the stream. Thus, technically, a Hoosier owning property along the Ohio River cannot legally cast a line into those waters without first obtaining a Kentucky fishing license, nor can he, legally, pick up a bit of sand or gravel from the stream.

Collier's, one of our best-known national weeklies, in its issue of March 15, carries an editorial, "Welcome Home, Doctor!" It mentions the fact that many testimonial dinners are being held in this connection, and makes the observation that rather than having a dinner "it would be far better to put on a campaign 'To Pay the Guy What You Owed Him When He Left, If You Owed Him Anything.'" The editorial mentions the fact that most physicians are poor bill collectors and that a little ready cash at hand when he again opens his office would come in mighty handy. We are in favor of such a program.

Some forty-eight years ago a young medical graduate, Dr. Max A. Bahr, became connected with the Indiana Central Hospital for the Insane, then considered as being "way out" on West Washington Street, in Indianapolis. The ancient-type "towers" of the building were landmarks for all who entered the city from the west. Incidentally, many—too many—of these buildings now are being used.

The other day Dr. Bahr had a birthday, his seventy-second, which marked the beginning of his forty-ninth year of continuous service in that hospital, serving as general superintendent since 1923, succeeding the late Dr. George F. Edenharter.

Shortly after Dr. Bahr became a part of the official staff, there was instituted the first "mental clinic" in this part of the country, and we believe that we were among the first to attend these classes. Dr. Bahr, then as now, had much to do with the clinic, and many of the cases exhibited and discussed stand out very clearly in our mind, after a lapse of so many years.

Again something new was added when, after a short time, a full-time pathologist was employed, one of the first in this section of the country—Doctor White; we do not recall his first name. Pathology of those days bears little resemblance to present-day teaching methods. Our own Dr. Frank Wynn, while an internist and a teacher of medicine in the old Medical College of Indiana, also was one of the early students of pathology, and he was the one who brought about the present Scientific Exhibit at the annual meetings of the American Medical Association.

Thus Doctor Bahr, nearing his "Golden Jubilee" in one of our oldest institutions, has attained a background such as is possessed by few men. He pioneered in many of the present-day accepted methods of treatment of the mentally ill, notably the treatment of paresis. His reports on this work attracted attention, not only in this country, but throughout the medical world.

THE JOURNAL congratulates Doctor Bahr on his record and trusts that he long may continue to serve as the head of the Central Hospital.

President's Page

American Medicine has undergone radical changes in the past fifteen years. Before this time the average sick patient was content to be treated in the home, no matter what the illness, except operative cases. Most babies were delivered in the home by the family physician, with no special help except possibly a neighbor lady who had had the experience of having babies of her own, or who had assisted in other cases of illness; in fact, that particular community considered her a good practical nurse regardless of her knowledge, even to the crudest of care.

This has all changed, and you know the trend at the present time; and with these changes there has come to pass a change in every phase of human endeavor that infringes upon our personal liberty, in many instances freeing us from the destroying elements of nature.

Science is moving at such a rapid pace that it is almost impossible to grasp all the implications and effects on life from all angles. So we as citizens and physicians must progress with it, although it compels us to change our way of thinking. For example, at the beginning of this fifteen-year period when a number of these activities were being proposed, they were labeled as "Socialistic" and "Communistic," but as time went on we accepted some of these proposals, such as government-supported hospital construction, government support of medical research and education, maternal and child health services, the public welfare plan under social security, and the medical insurance plan.

The reason for the above statements is the fact that medical men did not propose these plans. They were forced upon us by reasons you can easily understand if you read the testimony of different individuals and groups before the House of Representatives' hearings on the Wagner-Murray-Dingell Bill. It seems to me that it is high time that a group of highly-educated men, and I refer to the medical profession, could put before the public a constructive program, in keeping with all other branches of science, that would solve the problem, which is better medical care for the citizens of the United States. It appears to me that all of our activities have been directed toward fighting some program that has been put before the public by other than the medical profession. Why not get a trial horse of our own?

We all agree that this widely-heralded lack of medical care to the public is not wholly traceable to the medical profession alone. Some of the blame should be placed upon the shoulders of the educational system of this country. I am reliably informed that three million adults in the United States have never attended school; that ten million citizens have had so little schooling that they are virtually illiterate; and that one-half of the brightest and most talented youths leave school prematurely.

If such a large number of future citizens get such a poor education, how are they going to evaluate their duties to their country and to themselves? How are they to evaluate health standards, except by apeing someone else?—and in so doing could possibly produce a viscious cycle, morally, physically, and mentally.

Every physician deals with this type of patient every day. We try to make our directions in the matter of health as simple as possible, but how often have our efforts failed because of a lack of understanding. Then the slogan should be: "Better General Education—Better Medical Care."

J. E. Farrell

EDUCATION OF THE VISUALLY-HANDICAPPED CHILD IN INDIANAPOLIS PUBLIC SCHOOLS

HILDA ALLDREDGE, B.A.
MARGARET CHAMPLIN, B.A.
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INDIANAPOLIS

Early in the Nineteen Hundreds an English ophthalmologist, James Kerr, in initiating a school health program, asked for an intensive survey of the vision of London school children. In the course of the investigation a deplorable condition was discovered in the schools for the blind. Because of the lack of a more suitable place in which to put them, children with a high myopic correction were enrolled in these schools and were studying and working with blind children. A report was made to the Second Congress of School Hygiene, which stated that since these children were not blind they should not be educated with the blind, and recommended that they be provided with a special class in which their needs and limitations would be considered.

In 1909 the first class which recognized eye difficulties in children was formed in London. It was called the School for Myopes, and over its door ran the legend, "Reading and writing shall not enter here." Thus it was to those early ophthalmologists that sight-saving classes owed their beginning. But, it is to present-day specialists that educators look for help and guidance in the Sight-Saving Program of the public schools.

Sight-saving classes in our country were first organized in Boston in 1912. From that time oculists and teachers have worked together in formulating regulations and qualifications which make a child eligible for enrollment in a sight-saving class. They are as follows:

Children having a visual acuity of between 20/70 and 20/200 in the better eye after all medical and optical help has been provided.

Children with serious progressive eye difficulties.

Children suffering from diseases of the eye or diseases of the body that seriously affect vision.

The responsibility of placing a child in a sight-saving class rests squarely on the attending ophthalmologist, so this may well be a matter to which the profession should give serious consideration.

Misnamed though they be, sight-saving classes do provide an educational opportunity for those children who are not blind, but whose visual acuity is so low that they cannot carry on their work with any degree of success under conditions provided for the normally-seeing child. The goal of all education is to help the child develop physically, mentally, and morally to the fullest extent of his innate abilities. The child with impaired vision often becomes a repeater in the regular classes. This constitutes a social and financial problem, as well as a personality problem.

The sight-saving class, with its special equipment, gives the low-visioned child an opportunity to achieve. He tastes success and is started on the road to becoming a useful citizen. He may have to depend on large print all his life, and on his ears for most of his education. The sight-saving teacher has time to give him the special attention he needs, and it is her job to find the best avenues of approach in accordance with the oculist's suggestions which have been sent to the teacher preceding the entrance of the child into a sight-saving class.

Children with low visual acuity use up more nerve energy trying to learn than does the child with normal vision. Better lighting, adapted materials, and shorter work periods alleviate this eye and nerve strain as much as possible. The result is a happier child and a more adjusted one.

In some states oculists often temporarily refer children who are recuperating from an eye operation, and who need the period of lightened curriculum before they take up the whole load again in regular classes.

The sight-saving class also serves those children who have a non-communicable eye disease in a regressive stage. Here again such children can continue their education, although on a limited program, with some measure of success.

Care of the eyes is stressed. Pertinent facts are taught; namely, going to an oculist periodically for an eye check-up; recognizing the kind of light necessary for various types of work; selecting reading material with good print; and guidance toward a life work which will not tax the sight too stringently—in short, the aims of the sight-saving class are to help the child learn basic rules of eye hygiene and get the best education he possibly can with a minimum of eye strain. Thus, he may fit more adequately into a world of normally-seeing people.

In the United States classes for the partially-seeing are operated on two general plans, the segregated and the cooperative. The proponents

The authors of this article are teachers of Sight-Saving Classes in the Indianapolis Public Schools.

of the cooperative classes point out the fact that segregation only serves to emphasize the child's handicap and deprives him of the normal contacts he should have with children of his own age-group. In Indiana the sight-saving pupil is not separated from the other children in the school, but in every situation where it is at all feasible he studies and plays with them. He does all work requiring much eye use with the sight-saving teacher, and passes to the regular grade in which he is enrolled for subjects he can learn by listening rather than by seeing. Thus, the boy or girl in the sight-saving class has reading, arithmetic, handwork, and typing with the sight-saving teacher, and goes to the other home room for music, social studies, English, and physical education.

The subject requiring most constant and continuous use of the eyes is reading. In the first two grades there is no dearth of good, attractive material in large type, but as the child is promoted to higher grades the type in regular textbooks becomes smaller. It is then that the teacher begins to see reading failure, and, what is even more serious, a growing dislike for the subject. Books printed in twenty-four-point type are used in the sight-saving class and are a direct answer to the above problem. As the children pass from primary and intermediate grades to the junior high school more reference-type work is required of them. A very limited amount of this material can be found in clear-type books. The greater amount by far must be read to the children by the sight-saving teacher. Science or social-study material may be dictated on the dictograph or typed on bulletin-type typewriters, and the children may listen or study these subjects at their own convenience.

Good health habits are stressed continually in the sight-saving class. It is not an unusual sight to see a sight-saving class member of long standing quietly move the desk of a younger child so that the light falls properly on his book.

It is in the teaching of arithmetic that material printed in large type is difficult to find. The sight-saving teacher must make individual assignments with a lettering pen and India ink on plain manila drawing paper. In classes where there happen to be three or four pupils in the same grade she prints the assignment in bold manuscript writing on the blackboard, and the children at their movable desks may work at whatever distance they wish from the blackboard. A great deal of classwork is done at the blackboard. This gives the children a chance to move about and also forces them to work at greater distances from the eyes. Drill material in large type may be found on the market, but the sight-saving teacher makes a great many of her own drill devices.

Touch-typing is taught in the sight-saving classes when the child reaches the fourth grade, or even a little sooner, if his hands are well-developed. Typewriters used are all of the bulletin-type and are of necessity harder and heavier of touch than the office machine. In sight-saving, typing is a tool rather than a vocational subject. It is in no way intended to fit one for secretarial work, as the shorthand and bookkeeping which would accompany it would be very taxing for the sight-saving pupil. Writing means following a point and following a line; it requires fine muscular co-ordination and is a source of eye strain. Touch-typing transfers to the fingers work ordinarily done by the eyes. By the time a sight-saving child enters junior high school he is able to type social study and science reports, and his English themes.

In the primary grades the art work in the regular grades is often of a type which does not tax the eyes unduly; hence, the visually-handicapped may do as much of it as he wishes. At about the fourth grade the work becomes more detailed, and then the children in sight-saving classes have all their art or handwork under the direction of their own teacher. Usually crafts are emphasized rather than art, although an effort is made by the teacher to build up a good color sense through the making of large posters in cut paper or colored chalk. A sight-saving child can make a simple basket without too much eye strain. He can do weaving that is big enough to be done with the fingers. Simple woodwork satisfies the creative urge to some extent. Brightly-colored maps painted on plywood three feet long and two feet wide are so attractive that they are often carried into the regular classroom and enjoyed by both teacher and children. Boys are encouraged to take all the work of the industrial arts or shop except printing. Girls take cooking, but do not enroll in the sewing classes unless given permission by the oculist.

Of paramount importance in every sight-saving class is the equipment with which it is furnished. Books are printed on buff-colored, unglazed paper in twenty-four-point type. None but the texts which have been proved good by use are printed, as it is a comparatively expensive operation. One ordinary reader will become three or four volumes in clear-type. The large size of the books makes the specially-built sight-saving desk almost imperative. This desk has a commodious top which can be raised and used as a bookholder. It can also be adjusted for different distances from the eyes. Plain manila drawing paper, lined with a three-quarter green line, is used for all assignments. The children never use ink and are provided with soft black pencils. Each room should be equipped with two bulletin-type typewriters. The talking book, the radio, and the dictograph are highly desirable. Large unlettered maps of the outline type are used, and the children make their own keys in the interpretation of them. Beautiful globes, also unlettered, in a soft, dull finish can be purchased on the educational-supplies market.

A well-balanced personality requires emotional

stability and physical and mental fitness. Frequently the pupil with defective vision who has been handicapped, perhaps from birth, is not so adequate emotionally as a normally-seeing child. This deficiency in his physical make-up may have caused undesirable behavior patterns and habits. These facts must be recognized and methods of counteracting their influence devised. The need for a teacher with a wholesome understanding personality is self-evident under these circumstances.

Many factors outside the sight-saving classroom must be considered in order to adjust the child to his handicap. The reaction of the regular classroom teachers when the cooperative plan is used is a vital factor. Equally as important is the reaction of the children in the school, the principal, the school nurse, the parents, and the doctors. It is much easier for a sight-saving pupil to adjust himself and become a normal individual if all these persons are in agreement as to their program and give full co-operation.

If a child is prejudiced against entering a sight-saving class, the fault lies in the attitude of an adult which is reflected in the child. Often a school nurse will report her findings of defective vision when a child first enters school, but cannot get the co-operation of the parents or the doctor.

Ben, a third grade pupil, was a problem child in his regular class room. The regular teacher said that it was impossible to keep him on his standard schedule. He was a poor reader; was not attentive; did not copy his work accurately from the board; had tantrums; and was easily upset emotionally. He did not seem interested and was fault-finding. If a classmate accidently bumped into him he was ready to fight; he was always on the defensive. The telebinocular test showed blindness in the right eye, and fingers visible at a few feet. The regular class-room teacher was not alarmed by this; she did not believe in sight-saving programs, particularly the co-operative type that would include her on a co-operative-program plan.

The mother had heard of sight-saving programs and asked the advice of the regular teacher who did not recommend entering the child in a sight-saving class, but suggested to the mother that this was a thing she should avoid if possible. The mother sought the principal's advice and the sight-saving teacher's opinion. Immediately she took Ben to an ophthalmologist who diagnosed his condition as a congenital cataract of the right eye. The good eye read 18/30; yet the specialist was not particularly interested in sending him to a sight-saving class. He did, however, consent to a trial in a sight-saving class since the parents felt they should try this program to see if it would help the physical condition of their child.

After Ben entered her class the sight-saving teacher found all the traits claimed by the regular class teacher to be true. She noticed that Ben turned his head to one side in order to see the reading material more easily. In the sight-saving class the reading material and class work were within his vision; proper lighting technique was used; nervous strain was eliminated; physical conditions were carefully checked; short study periods were adjusted to eye limitations; handwork was prepared for relaxing tense nerves and relieving eye strain; and individual attention was given subject matter.

In the summer Ben was given another check-up and the eye specialist now found a cataract growing rapidly in the good eye. Now it became a race with time to see if the cataract on the right eye could be treated and a certain amount of vision restored in it before the cataract in the left eye would destroy his vision entirely.

Although Ben lost several weeks of school while the right eye was being needled, he was able to keep his studies up to standard for his grade while all this change in vision was taking place. Now he understands what physical activities may be denied him and is calmly prepared to face life under great difficulties and nervous strain. He has become another personality; a happy, wholesome, well-balanced being with a feeling of success in his work and in his contact with others.

In measuring the effectiveness of a sight-saving class we must first consider our primary aims:

(1) To give an education at the least possible cost to vision.

(2) To improve vision under special lighting and equipment, even to the extent of the pupil being able to return to regular classes.

(3) To retard certain diseases, the prevention of further loss of vision.

(4) To measure the degree to which the child has been able to achieve normal progress.

(5) To continue sight-saving class habits after the pupil leaves school.

Ocular conditions can be measured, and this is one way of measuring effectiveness in the sight-saving classroom. If it can be shown that static ocular conditions were not lowered during the time a pupil attended a sight-saving class, or that any change which took place was an improvement, this would be definite proof of the preventive function of the sight-saving class.

During the last four years twenty-eight sight-saving cases have been enrolled in one of the Indianapolis classes; twelve of this number are still enrolled.

Last year the ocular report showed improvement in vision in one-third of the children tested; in one-half the vision was the same; and one-sixth showed further loss of vision. Of the number attending high school three quit at the age of sixteen, while eight children who entered high school are still enrolled. The honor roll claimed two, and one took part in basketball; and one boy played on the second team in final line-up in the sectional tourney. Partially self-supporting are two of this group. One boy works under the supervision of his father in a packing warehouse

where he labels canned goods and takes phone orders; another is employed in bicycle repair work, and during the summer made a living wage by working in a garage. It was interesting to note that the vision of two children had improved to the extent that they returned to regular classroom work, and four children withdrew, not from choice but because of out-of-town residence where no sight-saving classes were available.

The results of training in ocular hygiene after a child leaves the sight-saving class is not so easily measured. If a child will habitually refrain from reading print other than *only* that which gives no eye strain, avoid working or concentrating too long on one task, and choose a vocation that does not necessitate eye strain, then the *sight-saving class* has fully accomplished its purpose.

TRACHOMA AND ITS POLITICAL COMPLICATIONS IN INDIANA

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The number of persons in Indiana who receive monthly assistance because of blindness has ranged between 2,551 in 1938 and 1,926 in 1945. About 10 per cent of them became blind from complications incident to trachoma. Most of these contracted the disease in childhood and youth.

Following the introduction of sulfonamides in the treatment of diseases of the eye, the Department of Public Welfare devised a low-cost method of applying sulfa drugs to certain apparently more favorable cases who were receiving monthly assistance because of blindness due to trachoma. Treatments were given under the direction of local oculists. In most cases the disease had left permanent scars in the eyelids and corneas which prevented recovery of vision; but a number regained enough sight to render them ineligible for further assistance, and the aggregate of savings made thereby exceeded the cost of medical care of all persons treated under this program. The average cost per case was less than the average amount expended per person for each month of assistance.

It was noted that in the active cases the acute symptoms promptly subsided under treatment. Only in the presence of acute symptoms is the disease readily communicated to uninfected persons, so the department instituted a routine of authorizing treatment for eligible persons who have active trachoma, even though the individual is hopelessly blind, in order to forestall the spread of the disease to the patient's family and associates.

Trachoma is a reportable disease in Indiana, and has been for many years, but the number of cases so far reported represents a very small per cent of the total who have the disease.

The Welfare Act, effective July 1, 1936, excluded male applicants under twenty-one and female applicants under eighteen years of age. The restriction applies alike to monthly assistance and to eye treatment. Practically all of the earlier applications for monthly assistance because of blindness due to trachoma came from persons in whom the disease was far advanced and in whom hope of recovery of vision was forlorn. Evidently most eligible cases of this class qualified for monthly assistance during the first years of the operation of the Welfare Act, since it is noted that new applicants in recent years are largely persons who file when they become old enough, and are then *blind*. It is the young age-group that is being neglected by the state at the ultimate but avoidable expense of their care by the state.

A bill was introduced before the 84th General Assembly to authorize the state to set up machinery for the care of the presently-excluded minor age-group who are victims of trachoma, and so make them eligible for treatment in the early stages of the disease when the prospects for cure are most hopeful, and therefore prevention of blindness among them most favorable. The bill was supported by the Indiana State Medical Association; it contained suggestions of suitable state agencies for the administration of the provisions of the bill should it become law, and among such suggested agencies were the State Board of Health and the State Department of Public Welfare.

At that time the latter agency was under attack; the charges were prosecuted with such vigor that a Welfare Investigation Commission was appointed. The commission submitted a thirty-page report, dated November 15, 1944. While the entire report merits perusal, pages 7, 8, and 9 are particularly enlightening. It appears that on the day a vote was to be taken, members of the assembly found on their desks some literature alleging that the Department of Public Welfare was sponsoring the bill and wanted it passed in their especial interests. The vote was adverse. The victims of this negative action are those minor age individuals who are deprived of the medical care that might save their sight, and the taxpayers who will have to bear the burden of providing for those who are destined to become blind inexcusably.

The political complications of trachoma in Indiana are resolved into three categories: Firstly, the failure to enforce the legal obligation to report cases of trachoma as well as those of chickenpox to the State Board of Health. Secondly, the failure to include in the Welfare Act of 1936 a provision for medical care of indigent, minor-age persons who contract communicable diseases that may and do lead to blindness when untreated; treatment of tuberculosis has no age restrictions. Thirdly, the willingness of some politically-minded faction to condemn future citizens to a life of darkness if that can help accomplish their partisan designs.

The only way to escape responsibility for the care of the blind is to prevent blindness.

RULES AND REGULATIONS REGARDING OSTEOPATHS

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At the last session of the legislature an amendment to the Medical Practice Laws of the State of Indiana, pertaining to osteopaths, was passed. Under the amendment, certificates for licenses may be issued to practice "osteopathy, medicine, surgery, and obstetrics." These certificates are to be issued "on the same terms and conditions as certificates to practice medicine, surgery, and obstetrics." This requires graduation from a school teaching medicine, including materia medica, and every other subject taught in a regular medical school.

A school which teaches all the subjects taught in a regular medical school, and osteopathy in addition thereto, is required to conform to exactly the same standards as are required of regular medical schools. The accrediting of a school of osteopathy so as to entitle its graduates to take examinations for a license hereafter is a prerequisite to obtaining a license to practice osteopathy, as well as medicine, surgery, and obstetrics, under the present law. There is no separate license to practice osteopathy separate from medicine, surgery, and obstetrics. Therefore, graduates from schools of osteopathy will not be in a position to take an examination until the investigation and accreditation of their schools have been completed. And if their schools fail to meet the standards in any point for accreditation of any regular medical school, their graduates will not be able to obtain a license.

But with respect to those who are already licensed to practice osteopathy, surgery, and obstetrics a different situation exists. Under the 1923 law those already holding license to practice osteopathy have the right to practice "osteopathy, surgery, and obstetrics," but not to use drugs except anesthetics, antiseptics, and narcotics. The 1945 Act provides that these already-licensed osteopaths "may, upon passing an examination in materia medica, as prescribed by the Indiana State Board of Medical Registration and Examination," and upon payment of one dollar, obtain a certificate for a license to practice osteopathy, medicine, surgery, and obstetrics.

It was the position of a majority of the Indiana State Board of Medical Registration and Examination that the already-licensed osteopaths should be required to complete courses of study in accredited medical schools in the subjects pertaining to materia medica before being permitted to take an examination before the Board in materia medica. That view was indorsed also by the Indiana State Medical Association, but the Attorney General held that the legislative intent did not include the requirement that already-licensed osteopaths complete such courses before taking the examination in the subject of materia medica.

Under another Act of the 1945 Legislature, all administrative bodies, such as the Indiana State Board of Medical Registration and Examination, that have the power to make rules and regulations in the carrying out of their duties must submit all proposed rules and regulations to the Attorney General "for approval as to legality; and when so approved, submit the same to the Governor for approval." Because of the ruling of the Attorney General as to legality, the provision contained in the rules proposed that already-licensed osteopaths complete materia medica courses in accredited medical schools before taking an examination before the Board was omitted. It follows from that ruling that the presently-licensed osteopaths in the state, totaling about one hundred and sixty-seven members, will be permitted to take an examination before the State Board, covering materia medica; and if they pass, to receive a a certificate for a license covering osteopathy, medicine, surgery, and obstetrics. The only change that would result would be that they would no longer be limited in the use of drugs to antiseptics, anesthetics, and narcotics; but no more osteopaths could be granted original certificates for license unless they graduate from accredited schools giving the entire course of studies required in an accredited, regular medical school.

LEGISLATION AFFECTING THE INDIANA STATE BOARD OF HEALTH*

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Rapid advances in medical science during the last few years have enabled physicians and members of allied professions to achieve more nearly their goal of preventing and curing diseases and prolonging life. One of the most important trends in modern medicine has been the rapid expansion of the field of public health. The increased awareness of the public of a need for better health protection places upon those of us concerned a greater responsibility and a need for complete understanding and co-ordination of efforts. The private physician and the public health worker have a common objective, to protect and improve the health of our citizens. The private physician's primary responsibility, of course, is to the individual patient. The public health worker is concerned with the public as a whole where health problems, because of their nature or extent, require co-ordinated community action. Each has an additional responsibility, however—the physician to the community and the public health worker to the physician.

A public health program, to be successful, must have the full understanding, co-operation, and support of organized medicine. Above all, those of us in public health must have the confidence of the physicians. Having common objectives, we must share our experience, our skill, and our counsel to develop and maintain the most effective methods of achieving that which both are seeking.

It is not enough to have the scientific knowledge available to prevent or control diseases. Indiana had thirty-three deaths from diphtheria in 1945. A specific immunizing agent for diphtheria is available which, if properly utilized, should result in neither cases nor deaths from this disease.

PROGRESS IN THE CONTROL OF COMMUNICABLE DISEASES

Unfortunately, there has always been a lag between knowledge and its application, between the need for action and action itself. The impression should not be left, however, that there has been no progress. The contrary is true. The decrease in the rate of communicable diseases during the last twenty-five years has been considerable. Much of the progress in this field, particularly as it relates to the enteric diseases, has been due to the efforts of the sanitary engineers, supplemented by the development of more effective immunizing agents. Improvement of public water supplies, sewage disposal systems, and the development of a safer milk supply have contributed greatly to the decline in communicable diseases. Between the years 1900 and 1940, life expectancy increased from forty-eight years to sixty-three years. A gradual decrease in general mortality has occurred throughout the country to a new low of 10.4 for the year 1944. Indiana, with a rate of 11.5, had a slightly higher rate than the nation as a whole.

Maternal mortality was 8.3 in 1900 and 2.1 in 1945. Infant mortality for the same periods was 155.5 and 34.5. These rates for the year 1900 are probably exaggerated due to incomplete birth registration. Longer life expectancy has resulted in a higher percentage of individuals in the older age brackets. Between 1900 and 1940 the percentage of persons over forty-five years of age increased from twenty to thirty. This, coupled with other factors, has resulted in a shift in the principal causes of death. (See Table I.)

In addition to the availability of medical knowledge and the necessity for its application, a third requirement is necessary in order to complete our picture. This concerns the legal structure under which we operate. Federal and state laws and city ordinances may and often do affect the administration of a sound public health program.

NEW BOARD OF HEALTH

It is generally conceded that no previous legislature in Indiana has done more than the 84th General Assembly to strengthen and extend the public health laws of the state. Of the health laws enacted, that providing for the reorganization of the Indiana State Board of Health is one of the most important. This changes the four-member bipartisan board to a nine-member board, to be appointed by the Governor. The terms of the board members are staggered so that there will be no complete change of board members during any one administration. This permits a continuity of

*Presented before a joint meeting of the Lake County Medical Society and the Northwest District Dental Society.

TABLE I

TEN PRINCIPAL CAUSES OF DEATH—UNITED STATES

1900	U. S.	Ind.	1940	U. S.	Ind.
1. Tuberculosis	194.4	187.7	1. Heart	292.5	319.7
2. Pneumonia	175.5	119.7	2. Cancer	120.3	127.3
3. Diarrhea (total)	142.7	98.6	3. Apoplexy	90.9	118.3
4. Heart	137.4	81.1	4. Nephritis	81.3	113.6
5. Apoplexy	106.9	89.9	5. Pneumonia	55.0	55.8
6. Nephritis	88.6	49.2	6. Tuberculosis	45.9	40.2
7. Cancer	64.0	42.8	7. Diabetes	26.6	28.1
8. Senility	50.2	45.8	8. Auto accident	26.2	35.7
9. Diphtheria	40.3	35.0	9. Premature birth	24.6	22.3
10. Premature Birth	32.4	28.3	10. Influenza	15.3	19.4

policy and program never before enjoyed by the Board of Health. Dr. D. R. Johns, of East Chicago, is chairman of the Board of Health. Dr. Jacob Oliphant, of Farmersburg, and Dr. James Wyatt, of Fort Wayne, are the other two physician members. Dr. Glenn Jenkins, Dean of the School of Pharmacy at Purdue University, is the representative of his profession. Professor Don Bloodgood, Associate Professor of Sanitary Engineering at Purdue University, represents the engineering profession. Dr. W. B. Currie, of Indianapolis, represents the dental profession. Dr. R. C. Julien, of Indianapolis, represents the veterinary profession. Miss Mary Heckard, superintendent of Nurses at the James Whitcomb Riley Hospital, represents the nursing profession. And last, but certainly not least, is Senator Howard Johnson, who is the lay member of the board. The act stipulates also that the Secretary of the State Board of Health, who is also the State Health Commissioner, shall be appointed by the board. Those of us who occupy full-time positions with the State Board of Health feel that we are most fortunate in having such outstanding men and women to determine the policies under which we operate.



ADVISORY HEALTH COUNCIL

Another act provides for an Advisory Health Council of twenty-five to forty-five members, to be appointed by the Governor from the membership of state-wide organizations concerned in matters of health. This Advisory Council will hold at least two semi-annual meetings in the Indiana State Board of Health Building, in Indianapolis. Although it has only advisory powers, it is felt that it will help the Health Commissioner and the State Board of Health to interpret the needs of the citizens of the state, and will serve, also, as a means of disseminating public health education.

HOSPITAL SURVEY AND LICENSING

Two very important acts were passed affecting existing hospitals and plans for additional hospital and health-center facilities. One bill provides that the State Board of Health shall license and inspect all hospitals wherein medical or surgical services are given to maternity cases or persons suffering from injury or disease. Indiana was the third state to pass such legislation, preceded only by Massachusetts and Minnesota. It further provides for an eight-member council to be appointed by the Governor, which will assist the State Board of Health in promulgating regulations, in establishing high standards of care, and in advising regarding matters pertaining to the violation of these regulations. Four of the members of this board will be persons engaged in hospital administration—one a member of the nursing profession, one a member of the medical profession. The Governor shall appoint a representative from the State Department of Public Welfare and one from the State Board of Health to serve as ex-officio members. It will

be the program of the Board of Health not only to inform the various hospitals and institutions offering bed care to the sick that they are not conforming to acceptable standards, but also to provide qualified consultants to assist them in correcting defects found. Two nurses on our staff, who have had special training in hospital administration, will be available to the hospitals for consultation and assistance. An experienced accountant has been selected to assist hospitals in their fiscal and record procedures. Engineering and other professional consultation services will be secured from the branch offices of the State Board of Health. Our foremost desire is to assist the hospitals to improve the efficiency of the care which they can give to patients. Our relationship to the hospitals will be one of co-operation rather than enforcement; of assistance rather than compulsion.

Another act directs that the State Board of Health make a survey of all existing hospitals and health centers in the state, to evaluate their sufficiency to supply the necessary physical facilities for furnishing adequate service to all the people of the state, and finally to compile such data and conclusions, together with a statement of the additional facilities necessary to supply such services in conjunction with existing structures. From the data collected, a plan will be prepared, with the help of an advisory committee, which will attempt to show the number and type of additional hospital and health center facilities needed to give the people of Indiana the necessary hospital care. Pending now is federal legislation, already passed by the Senate, which would make grants-in-aid available to states for hospital and health-center construction. The principle of this bill has the endorsement of the American Medical Association and the American Hospital Association. It requires that a state agency make a survey of hospital and health center facilities in the state to determine need and extent of need, and prepare a plan showing where additional facilities are needed. This conforms to the survey program as directed by our own state legislature. A local community, desiring to construct a hospital, aided by federal funds, must submit its plan to the responsible state agency to determine whether or not the proposed local development fits into the over-all state plan for hospital facilities. This is intended to prevent a hit-and-miss type of construction, as has occurred in some public works programs.

Occasionally well-meaning lay groups must be cautioned that a building alone does not constitute a good hospital. In addition, competent physicians and well-qualified pathologists and roentgenologists are needed in order to give to the patients the full benefits of modern medical science.

NEW DIVISION OF DENTAL HEALTH

Authority was also given for the establishment of a Division of Dental Health. It has been estimated that ninety-five per cent of the population of the country have dental defects. Among the first two million registrants for Selective Service, one in every twelve was rejected because of dental defects. The rejectee rate became so high that the minimum qualifications were lowered, and men with dental defects were taken into the armed forces and their defects corrected after induction. It is also recognized that present dental manpower is sufficient to care for only twenty per cent of the dental defects present. This means that seventy-five per cent of the population could not receive dental care even though they requested it. The Indiana State Dental Association has been most interested in this problem, and desirous of finding ways and means of an equitable solution. A state dental health council, consisting of five members, together with the President and Secretary of the State Dental Association, has been appointed for the purpose of working with the State Board of Health and its dental director in developing a sound dental health program.

There is no fully-accepted preventive for dental caries at the present time. In the past, dentists have encouraged better oral hygiene, earlier and more frequent visits to the dentist, and a low carbohydrate diet among children. Recently there has been considerable experimental evidence indicating that sodium fluoride, either applied topically in a 2 per cent aqueous solution, or applied to public water supplies in one part per million, may reduce dental caries in children from forty to sixty per cent. Grand Rapids, Michigan, and Newburg, New York, are adding sodium fluoride to their public water supplies in the amount of one part per million with nearby cities being used as controls. It should be emphasized that the work so far is entirely experimental, and no definite opinion can be given at this time. It does appear, however, to offer the most encouraging bit of evidence so far developed of a means of lowering the amount of dental decay.

Another act includes a stipulation that the State Board of Health "shall provide facilities and personnel for research investigation and dissemination of knowledge to the public concerning the health of persons of middle and advanced age and diseases common thereto." This new division is called "Adult Hygiene and Geriatrics." We would expect an increase in the amount of degenerative diseases with an increase in the number of persons in the older age bracket. However, there is considerable evidence to show that there is an actual as well as a relative increase in certain of these degenerative diseases, especially cancer and heart diseases. Public health programs in this field are and must be directed toward health education of the public and encouragement of regular examinations to the purpose that earlier diagnoses may be secured.

PASTEURIZATION LAW

A very important act pertaining to the sale or exchange of milk and milk products provides amendments to laws making it mandatory for these prod-

ucts to be pasteurized in accordance with specific regulations of the State Board of Health. Exception is given to cheese made from unpasteurized milk which is aged or ripened in accordance with specific regulations of the Board of Health. Also excepted are milk and milk products sold directly by individuals having cows which have been inspected and certified as free from Bang's disease and tuberculosis.

MERIT SYSTEM APPLIED TO BOARD OF HEALTH

The effectiveness of any organization is in direct relation to the quality of its personnel. Selection of professional individuals through open, competitive examinations, based upon qualifications and experience rather than political, personal, or other affiliations, has been made possible through the application of merit system programs. The final stimulus for this, in many states, came from federal agencies. They made it mandatory that personnel of any organization utilizing federal grant-in-aid funds must qualify under a merit system. This makes for a career service in public health. It enables administrators to attract and retain competent, well-qualified professional personnel. These individuals, in turn, are aware of the potentialities of their positions, and that promotions and salary increments will be based upon the merit of their work. No one contends that a merit system or a civil service system does not have some faults. The federal Civil Service System has been in operation approximately seventy years, and it still has some defects, so state agencies, most of which have been operating only since 1939, should have the understanding and support of all professional groups. Qualified personnel to carry out the comprehensive program visualized could never be secured unless public health is made a career service with compensation commensurate with training and experience. In most states, merit systems apply only to personnel on a state level, but before long they will apply to individuals employed locally.

FULL-TIME LOCAL HEALTH DEPARTMENTS NEEDED

We believe that we have two of the factors necessary to promulgate a sound and progressive public health program in Indiana; namely, the knowledge and the legislative background. We still lack to a considerable degree the machinery to apply this knowledge. In an effort to give better service from the State Board of Health and to make our personnel more easily available to local health officers and physicians throughout the state, there have been established five regions in Indiana which are really miniature state boards of health. The headquarters for these will be Valparaiso, Fort Wayne, Columbus, Terre Haute, and Washington. Most of the ordinary services previously available from the State Board of Health, with the exception of laboratory and vital statistics, will be provided by the branch offices.

Ultimately, however, we must and should depend upon local organizations for the recognition and assumption of responsibility of local problems. Local communities do assume the responsibility for the education of their youngsters. They assume also responsibility for police and fire protection. It is believed that health is more basic and essential than any of these, and until local communities do establish their own health departments, under home direction, manned by full-time physicians, engineers, nurses, and technicians, we will not be able to apply effectively the knowledge that we now have to prevent disease and prolong life. There is legislation which permits counties and cities to combine, or permits two or more counties to combine, for the purpose of establishing health departments, and also permits health departments to receive gifts or endowments from unofficial sources. The American Medical Association has endorsed full coverage of the nation by local health departments manned by full-time people, and has this to say about personnel: "The career of public health as a specialty of medicine requiring graduate university training is so far accepted as part of the pattern of preventive medicine that the survival of the part-time general practitioner as the local administrator of a health department cannot be encouraged by the medical profession or be recommended to the taxpayer as the best his money can buy in public health."

The Indiana State Medical Association has endorsed full coverage of the state by local health departments.

There is work ahead for all of us. We, of the medical profession, should continue to develop methods, establish acceptable standards, and, above all, provide an enlightened leadership to our allied professions and to the public. The Indiana State Board of Health asks for your continued confidence, understanding, and support.

ABSENCE OF VENOUS PULSATION ON THE DISK

Venous pulsation on the optic disk is a normal phenomenon. Its absence indicates stasis of the intra-ocular venous circulation; usually the stasis is due to intracranial hypertension in an early stage, before cerebral edema develops. Examination by spinal puncture is required for a diagnosis.

VALE, "TOMMY"; VADE, RAY!

Fears of the Indiana State Medical Association officers that "we might lose 'Tommy'" became a reality on April fourteenth, when Thomas A. Hendricks, who had served as its executive secretary for more than twenty-one years, resigned, effective May 1, 1946, to become full-time secretary of the Council on Medical Service and Public Relations of the American Medical Association.



Thomas A. Hendricks

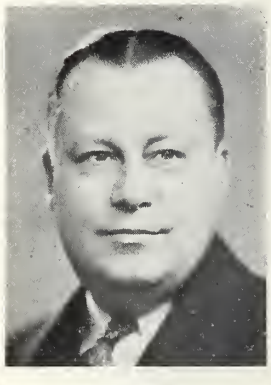
Since March, 1945, Mr. Hendricks has been serving as part-time secretary of the Council, commuting between Indianapolis and Chicago, so to speak. In being called to full-time service, Mr. Hendricks enters a nation-wide field. Among the duties of the Council is the setting up of standards for, and the co-ordination of, the numerous prepayment medical care plans throughout the country.

While the Indiana State Medical Association is itself sustaining a loss in Mr. Hendricks' leaving, it is a distinct promotion for him. His office will be in the American Medical Association headquarters' building in Chicago. He has sold his home in Indianapolis and has established permanent residence at Culver, Indiana, where he owns a summer home on Lake Maxinkuckee. "I will always be a Hoosier, and will continue to live in Indiana," said Mr. Hendricks.

Mr. Hendricks left *The Indianapolis News* in December, 1924, to become the first full-time secretary of the association. In the twenty-two-year period, from 1924 to 1946, he has seen the state membership grow from 2,535 to nearly 3,400 members. "Tommy," as he is familiarly known far and wide, has contributed immeasurably to the high position now held by the Indiana State Medical Association in organized medicine.

Prior to his association with the Council on Medical Service and Public Relations, Mr. Hendricks served as a consultant to the Procurement and Assignment Service at Washington, D.C., for three years. Mr. Hendricks' multiple duties during the war emergency and his part-time association with the American Medical Association has, indeed, made him fit into the picture portrayed by James Whitcomb Riley's "Good-bye er Howdy-Do":

"Say good-bye er howdy-do-
What's the odds betwixt the two?
Comin'—goin'—every day—
Best friends first to go away—
Grasp of hands you'll rather hold
Than their weight in solid gold,
Slips their grip while greetin' you,
Say good-bye or howdy-do?"



Ray E. Smith

But as Mr. Hendricks leaves us to enter upon an even bigger role with the American Medical Association, Mr. Ray E. Smith, who has for the past year served as secretary of the Indianapolis Medical Society and part-time assistant executive secretary of the Indiana State Medical Associaiton, takes over—having been appointed as executive secretary of the Indiana State Medical Associaton at the Council meeting held in Indianapolis on April fourteenth.

Mr. Smith is a native Hoosier, born at Huntington, Indiana; is a graduate of DePauw University; and in addition to his journalistic experience has also served Indiana in an executive capacity, first being appointed as penal affairs secretary and later as executive secretary to the former Governor Henry F. Schricker. He has also served as reporter for *The Franklin Evening Star;* city editor of *The LaPorte Argus;* editor of *The LaPorte Herald-Argus;* managing editor of *The Michigan City Evening Dispatch;* and editor of *The Hoosier Sentinel.*

The Indiana State Medical Association is, indeed, fortunate in being able to engage the services of Mr. Smith, whose administration will undoubtedly add another pillar to the portals of the Indiana State Medical Association and Hoosier Medicine.

OUR NEW ASSOCIATE EDITOR

We take pleasure in announcing that our own Dr. N. K. Forster, of Hammond, who served as president of the Indiana State Medical Association during 1945, was named associate editor of THE JOURNAL of the Indiana State Medical Association, at the Council meeting held in Indianapolis on April fourteenth.



N. K. Forster, M.D.

Doctor Forster needs no introduction, for he is well known in Indiana Medicine, as well as throughout the Union. His literary ability has won him recognition throughout medical annals; a long list of scientific articles having been published in the A.M.A. and other journals, in addition to the Fellowships he holds in several national organizations and his membership in some fifteen medical societies. His activities and participation in Indiana Medicine throughout the years have been so many that his record at the association headquarters resembles that of a bibliography, ranging from that of chairman of the various committees to councilor, and finally president of the association. He also served as editor of the *Lake County Medical News* from its inception until about three years ago, his publication attracting much attention.

He was born in Montana; received his B.A. and M.A. degrees at Gonzaga University, Spokane, Washington; took some additional work at the Worcester Academy in preparation for special work at the Massachusetts Institute of Technology; worked in the motion picture industry for four years; and entered the Southern California Medical Department in 1915; transferring to the University of Illinois College of Medicine in 1917, from where he received his M.D. degree in 1919. He took postgraduate work at the University of Chicago and Northwestern University; and has served in the Medical Reserve Corps and the Student Army Training Corps.

He came to Hammond in 1924, and while engaged in general practice, his work in recent years has consisted largely of industrial surgery.

Doctor Forster is an invaluable addition to THE JOURNAL staff, and the Indiana State Medical Association is, indeed, blessed in having him among its leaders in these parlous times of ominous socialized medicine.

STATE GERIATRICS INSTITUTE PLANNED FOR MAY

A one-day Geriatrics Institute, sponsored by the Indiana University School of Medicine and the Indiana State Board of Health, will be held in the auditorium of the Indiana University School of Medicine, Wednesday, May 22, 1946. The purpose of the institute is to study the process of aging, the problems of the aged, and the more common diseases and disabilities associated with aging. In attendance will be physicians interested in geriatrics, educators, dentists, nurses, social workers, representatives of industry and labor, and, in fact, all who may have an interest in the medical, social, and economic problems connected with the rapidly-increasing age of our population.

The forenoon session of the institute will be devoted to a discussion of "Health Guidance in Maturity" and "Mental Hygiene and Geriatrics," with a symposium on "Diseases of Advancing Years," including cardiovascular-renal diseases, arthritis, cancer, eye and ear diseases, and hormone therapy. Dr. W. D. Gatch, Dean of the Indiana University School of Medicine, will preside at the forenoon session of the institute.

Dr. L. E. Burney, State Health Commissioner, will preside at the afternoon session. The afternoon program will be devoted to an address on "Geriatric Medicine," by Dr. E. J. Stieglitz, Washington, D. C., Consultant in Gerontology to the National Institute of Health, and author of a book on geriatric medicine. As a further part of the afternoon program, the subject, "Aging as an Industrial Health Problem," will be discussed by a representative of labor, a representative of management, and an industrial physician.

A public meeting in the evening, to be addressed by a speaker of national reputation and experience, is planned as a conclusion to the institute. All the facilities of the Indiana University School of Medicine and of the State Board of Health will be devoted to making this institute a success and in creating a widespread interest, both professional and public, in the purpose of the institute. The program will begin at 9:00 A. M., continue throughout the day, and close with the evening meeting for the general public.

OFFICIAL CALL

To the Officers, Fellows, and Members of the American Medical Association:

The ninety-fifth annual session of the American Medical Association will be held in San Francisco, California, from Monday, July the first, to Friday, July the fifth, nineteen hundred and forty-six.

The House of Delegates will convene on Monday, July the first.

The Scientific Assembly of the Association will open with the General Meeting held on Tuesday, July the second, at 8:00 P.M.

The various sections of the Scientific Assembly will meet Wednesday, July the third, at 9:00 A.M., and at 2:00 P.M., and subsequently according to their respective programs.

ROGER I. LEE,
President, American Medical Association
R. W. FOUTS,
Speaker, House of Delegates

DEPARTMENT OF MEDICINE AND SURGERY IN THE VETERANS ADMINISTRATION

With the signing of *H.R. 4717* by the President, now *Public Law 293*, there was created in the Veterans Administration a Department of Medicine and Surgery under a chief medical director. General Bradley announces that he has designated General Paul R. Hawley to serve as Acting Chief Medical Director. This act will bring professional personnel into an organization comparable with the Army and Navy Medical Corps and the United States Public Health Service.

General Bradley immediately authorized the employment of physicians, nurses, and dentists to fill existing vacancies. There is an immediate need for 1,125 doctors, 1,200 nurses, and 100 dentists.

Among the major provisions are:

1. Specialists certified by VA will be paid 25 per cent more salary up to a ceiling limit of $11,000 a year.

2. Residencies will be set up in VA hospitals where younger doctors may train to qualify as specialists. This will mean that veterans will be able to obtain the most up-to-date medical treatment—the same as if they were admitted to hospitals connected with the nation's leading medical schools and centers.

3. Promotions will be made on recommendations of special VA boards, which in general compare with the "selection boards" operating in the Army and Navy for higher-ranking officers.

4. Office of Chief Medical Director: The director will be paid a salary of $12,000 a year. A Deputy Medical Director will receive $11,500, and Assistant Medical Directors—not to exceed eight in number—will be paid $11,000 each.

5. Medical Service:

Chief grade, $8,750 minimum to $9,800 maximum.

Senior grade, $7,175 minimum to $8,225 maximum.

Intermediate grade, $6,230 minimum to $7,070 maximum.

Full grade, $5,180 minimum to $6,020 maximum.

Associate grade, $4,300 minimum to $5,180 maximum.

Junior grade, $3,640 minimum to $4,300 maximum.

6. Appointments of key executives will be for a four-year term, subject to removal by the administrator for cause. Reappointment will be for the same term.

7. Doctors, dentists, nurses, and technicians now employed by the VA will be continued on their present jobs pending determination of their qualifications for appointment in the new medical department.

8. Another provision of the act which will permit professional improvement of VA medical personnel will allow up to five per cent of such employees to study or do research work for periods of time up to ninety days. This will enable doctors, dentists, nurses, and technicians to attend recognized schools or work with the United States Public Health Service or other research groups. Officials pointed out that this would enable workers to keep abreast with the very latest developments in their respective fields.

9. Although they are not subject to selection or promotion by Civil Service, the members of the new VA Department of Medicine and Surgery will be under the Civil Service Retirement Act of 1920, and will receive its benefits.

General Hawley, commenting on the President's action, said:

"With the signature of the Medical Department Act, our objective is clear—a medical service for the veteran that is second to none in the world. Around the splendid nucleus of excellent men and women in the VA medical service we shall build such an outstanding service."

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS
WASHINGTON OFFICE

All Aboard for San Francisco!

Wonderful Seventeen-Day Vacation Trip to A.M.A. Session and The Great Northwest

Would you like to attend the annual session of the American Medical Association, in San Francisco, July 1 to July 5?

Have you wanted to visit Salt Lake City, Las Vegas, Los Angeles, Hollywood, Portland, Vancouver, Lake Louise, Banff Springs, and Winnipeg?

Do you feel the need of a **real** vacation . . . the urge to travel . . . to view scenic splendor . . . to relax in luxurious and comfortable air-conditioned Pullmans?

If so, then the special trip to San Francisco arranged by the headquarters' office of the Indiana State Medical Association, by authority of the Council, will interest you. You can "get aboard" by writing to Ray E. Smith, the executive secretary, 1021 Hume Mansur Building, Indianapolis 4, Indiana. Reservations will be filled in the order received.

WRITE FOR HOTEL RESERVATIONS

Everything will be arranged for you except your hotel reservations in San Francisco. They are being handled by Dr. M. Lawrence Montgomery, chairman of Subcommittee on Hotels, 200 Civic Auditorium, San Francisco. A list of the San Francisco hotels, their rates, and a blank for making reservations are published each week in the back pages of The Journal of the American Medical Association. Write to Dr. Montgomery for your room today!

The cost of the trip includes your room at the Rosslyn Hotel, in Los Angeles. These reservations are being made for you by the executive office. This is being done to guarantee hotel accommodations.

COST OF TRIP

(Prices quoted below include round-trip Railroad and Pullman Fares, Transfer Charges at Los Angeles, Double Room with Bath at Los Angeles, and All Sight-seeing Trips as listed in Itinerary.)

	From INDIANAPOLIS	*From CHICAGO*
Two persons occupying lower berth, each	$241.95	$229.41
One person occupying lower berth	277.93	265.39
One person occupying upper berth	260.93	248.39
Two persons occupying drawing room, each	344.80	332.26
Three persons occupying drawing room, each	298.52	285.98
Two persons occupying compartment, each	316.59	304.05
Three persons occupying compartment, each	279.72	267.18
Two persons occupying bedroom, each	284.71	272.17

WHAT THE PRICE OF THE TICKET WILL INCLUDE

The price of your ticket will include round-trip railroad fare from Indianapolis or Chicago; Pullman fare from either city; hotel accommodations in Los Angeles (double room with bath), and sight-seeing costs at Salt Lake City, Las Vegas and Boulder Dam, Portland, Vancouver, Lake Louise, and Banff Springs.

Because food is such an individual matter, no meals are included in the ticket price. Passengers may spend as little or as much as they wish. Neither are sight-seeing costs in Los Angeles or San Francisco included.

ITINERARY OF THE HOOSIER PARTY

Tuesday, June 25—Leave Indianapolis at 1:30 P.M. Arrive in Chicago at 6:00 P.M. Leave Chicago at 9:15 P.M. Those who prefer may board the train in Chicago.

Wednesday, June 26—Arrive at Cheyenne, Wyoming, at 7:45 P.M. Leave Cheyenne at 8:15 P.M.

Thursday, June 27—Arrive at Salt Lake City, Utah, at 10:30 A.M. Special tour of city, taking in a portion of the old Mormon Trail, and returning at noon for the organ recital in the Mormon Tabernacle. Leave Salt Lake City at 10:00 P.M.

Friday, June 28—Arrive at Las Vegas, Nevada, at 11:00 A.M. A typical wide-open, western town. Side trip to Boulder Dam; a drive about the town in the afternoon, and a glimpse of Las Vegas night life. Leave Las Vegas at 10:45 P.M.

Saturday, June 29—Arrive at Los Angeles at 10:00 A.M. Check in at the Rosslyn Hotel. No sight-seeing arranged due to diversity of entertainment in this city and in Hollywood.

Sunday, June 30—Leave Los Angeles at 9:00 P.M.

Monday, July 1—Arrive in San Francisco at 9:00 A.M. Five days to attend A.M.A. sessions and enjoy numerous attractions of the "Golden Gate."

Friday, July 5—Leave San Francisco at 4:00 P.M.

Saturday, July 6—Arrive at Portland, Oregon, at 1:05 P.M. Four-hour scenic drive along the Columbia River Highway, viewing 620-foot Multnomah Falls, snow-spired Mount Hood, and other points of interest in "The Rose City." Leave Portland at 11:30 P.M.

Sunday, July 7—Arrive at Seattle, Washington, at 6:15 A.M. Leave Seattle at 8:30 A.M. Arrive at Vancouver, British Columbia, at 2:15 P.M. Five-hour stopover in this large western Canada seaport. Tour along Marine Drive, beaches, Stanley Park, and business and residential areas. Leave Vancouver at 7:15 P.M.

Monday, July 8—Arrive at Lake Louise station at 4:30 P.M. Party will be taken to Lake Louise in cars. After witnessing sunset in this "most lovely spot in North America," party will return to the train for the night.

Tuesday, July 9—Leave Lake Louise at 9:10 A.M. Arrive at Banff Springs at 10:10 A.M. Entire day devoted to sight-seeing and out-of-door sports. Leave Banff Springs at 6:10 P.M.

Wednesday, July 10—After riding through the great grain belt of the Northwest, arrive at Winnipeg, Manitoba, at 7:45 P.M. Sleeping cars may be occupied for the night at no additional expense. Rooms will be available at the Royal Alexandria Hotel for those who desire. Cost of hotel rooms is extra. Winnipeg abounds with merchandise. United States money is 10 per cent above Canadian money in exchange. One hundred dollars of merchandise may be brought across the border without paying duty. Time is free for shopping and sight-seeing.

Thursday, July 11—Leave Winnipeg at 6:55 P.M.

Friday, July 12—Arrive at St. Paul at 8:05 A.M. Leave St. Paul at 8:30 A.M. Arrive at Chicago at 6:00 P.M. Leave Chicago at 9:20 P.M.

Saturday, July 13—Arrive at Indianapolis at 2:00 A.M.

Changes in railway schedules may slightly alter foregoing time of arrival and departure, but not to any large degree.

INDIANA MEDICAL CARE PLAN ORGANIZATION COMPLETED

The Indiana Medical Care Plan, which will be operated by Mutual Medical Insurance, Inc., has elected the following physicians as officers:

President	Walter U. Kennedy
Vice-President	W. Harry Howard
Secretary	Walter L. Portteus
Treasurer	A. F. Weyerbacher

Physician membership of the Board of Directors was completed by the election of Dr. Alfred Ellison, of South Bend, and Dr. Walter L. Portteus, of Franklin. The other members of the board had been named in the Articles of Incorporation at the time they were filed, but Dr. Ellison and Dr. Portteus being out of the state at that time, their names were omitted from the list originally filed. The entire membership of the board at present is as follows:

Irvin C. Barclay	Evansville
Claude S. Black	Warren
Cyrus J. Clark	Indianapolis
Eldo H. Clauser	Muncie
Franklin S. Crockett	Lafayette
James H. Crowder	Sullivan
Wemple Dodds	Crawfordsville
Alfred Ellison	South Bend
Jesse E. Ferrell	Fortville
Augustus P. Hauss	New Albany
W. Harry Howard	Hammond
Walter U. Kennedy	New Castle
Maurice R. Lohman	Fort Wayne
Albert M. Mitchell	Terre Haute
Charles F. Overpeck	Greensburg
Walter L. Portteus	Franklin
Floyd T. Romberger	Lafayette
A. Jerome Sparks	Fort Wayne

A form of contract for clerical and similar office work and for the enrolling of employees and other types of groups has been approved. Two things remained to be done to put the plan into active operation: (1) complete the raising of guaranty funds; and (2) adopt a schedule of indemnities, of benefits.

The raising of the guaranty funds is progressing with accelerating speed as the medical profession is becoming better informed regarding the plan. The schedule of indemnities is being worked out with utmost care, with the purpose of having the benefits and the premiums charged on a thoroughly sound actuarial basis, and at the same time being as fair to the entire medical profession as it is humanly possible to make it.

Letters have been sent out to the physicians of the state requesting their subscriptions to the guaranty fund. There is a tendency by people who are busy, as most doctors are, to put off whatever they are not driven by the exigencies of the moment to do. Signing and returning a subscription with a check attached is one of the things likely to fall into the class of things that can wait until tomorrow. This may lead to the necessity of additional letters or some personal solicitation. And that would use up some of the money that could otherwise be used in getting into operation. So all physicians who have not made their subscriptions are urged to give this matter immediate attention. If you do not have conveniently available the subscription blank you received through the mail, it will be sufficient to complete a subscription by simply mailing your check, made payable and directed to

Mutual Medical Insurance, Inc.,
544 Consolidated Building,
Indianapolis 4, Indiana.

Immediately upon receipt of your check at that address a Certificate of Advancement, showing your payment, will be mailed to you.

Attend the Annual Meeting

of the

INDIANA STATE MEDICAL ASSOCIATION

INDIANAPOLIS

Tuesday, Wednesday, and Thursday

October 29, 30, and 31, 1946

Make your plans for the Convention now!

Make your hotel reservations now—rooms are scarce and the attendance this year is expected to be the largest ever. A reservation will be accepted now; later on it may be more difficult to secure just what you want.

Bring your wife—or let her bring you. The Indianapolis Woman's Auxiliary is making plans to entertain the physicians' wives, and shopping service is always available.

Doctors and their wives are to be guests at a theater party on Tuesday night, October twenty-ninth.

The banquet will accommodate all who wish to come—and everyone will be there. The Murat Temple will be the headquarters.

Sports are back on the program—

Golf, Trap Shoot and .....

The 1946 Convention slogans are:

"We want you to come!"

"We are glad you are here!"

"We want you to have a good time!"

"We want you to come back!"

COMMITTEE ON CONVENTION ARRANGEMENTS.

WHICH MEDICAL PLAN DO YOU FARMERS FAVOR?

(Reprinted from "The Farmers Guide.")

"At almost every turn of the road one comes face to face with some plan or discussion or experiment having to do with medical and surgical care for the American people. The plans range all the way from proposals in Congress that would socialize medicine, making it a political puppet, a President Truman plan, to the non-profit mutual indemnity insurance plan of physicians themselves.

"It seems quite certain that out of this mass of conflicting ideas will come in the near future a nation-wide plan of voluntary medical care for the American people. The important thing to watch now is that a plan is not forced on the people that eventually will carry every phase of socialized medicine. The American public did not take kindly to the first plan that included such revolutionary ideas as (1) all physicians under government control; (2) assignments to be made by the U. S. medical authorities (and here is where the political pulls would come in); (3) a tax to be levied on every American citizen to bear the heavy cost; (4) all doctors on the government-salaried pay roll; (5) the sick would have to go to the physician in their territory, with certain opportunities to go to specialists chosen for the district, and other similar duties.

"STOP, LOOK, LISTEN

"Out of this came less drastic suggestions in which, on the face, there appeared more voluntary opportunities, but warning has been sounded that it is a very short stop from 'take it if you want it' to 'you must pay your share.'

"*The Farmers Guide* has carried many articles on this subject and a few months ago conducted a poll seeking the views of Guide readers on socialized medicine. The opposition was overwhelming, less than ten approving, and several of these with reservations.

"Senator Claude Pepper has just made public a report by the Bureau of Agricultural Economics, describing the rural prepaid medical care experiments of the United States Department of Agriculture. The experiments were practically failures because of the lack of interest and non-participation of those having opportunity to accept the plan. The report concludes: 'To take full advantage of modern technological advancement in health services it is necessary that the plan for rural people be coordinated with a broader plan for the entire population.'

"In 1941 six county-wide rural health programs were initiated in counties in Texas, Georgia, Mississippi, New Mexico, Arkansas and Nebraska. In each county special medical care organizations were established. All the families in the county could join by paying a small fee in advance. The average cost was $20 a year per family. The government put up an average of $25 a year per family to cover the difference between what the people could afford to pay, based on their average annual cash incomes of $785 per family, and the actual cost of the program.

WHAT PLAN INCLUDED

"Member families in the experimental groups were assured a free choice of medical practitioner, and were entitled to comprehensive medical service within the resources of the county. These included general medical, surgical, hospital and dental care.

"Despite the heavy tax subsidy and the apparently low cost, the report said, less than half the eligible families actually joined. The plans were hindered in their full effectiveness by the poverty of the county's inhabitants and drastic doctor shortages.

"The report concluded that voluntary health insurance plans, even though assisted by public funds, do not attract sufficient numbers of people to make them fully successful. Their instability is accentuated by the fact that these voluntary plans are subject to a very large turnover in membership. As the report says, 'Those who used the plan least were the ones tending to drop out, i.e., sicker families tended to stay on.' The report covers 166 pages.

MEDICAL ASSOCIATION PLAN

"The Indiana State Medical Association, dead set against socialized medicine and government politically-controlled medicine, through its House of Delegates, has authorized the creation of a corporation to be financed by contributions totalling $65,000 before the plan is put in effect. This sum will be raised by solicitation of physicians and other interested persons.

"The plan is the result of three years' study, and according to Dr. J. E. Ferrell, Fortville, association president, is a means to provide the best of medical care to all people. 'It is one among 50 voluntary sickness insurance plans operated with the approval and under the guidance or direction of state and county medical societies in the United States,' he said.

" 'This is a civic and community movement on a non-profit basis organized in the hope that financial burdens of sickness will be alleviated by the insurance principle,' says Dr. W. U. Kennedy, of New Castle, chairman of the council insurance plan.

EIGHTEEN DIRECTORS

"The plan, to be administered under the guidance of the state medical association, will have a board of eighteen directors and will be known as the Mutual Medical Insurance, Inc. The articles of incorporation specify that $25,000 will be deposited with the department of insurance, with $40,000 for operating and organization expenses. An additional $25,000 will be required as advance payments before operation begins.

"Full details of how it can be used by the individual are expected to be announced later.

"The plan of the physicians is one of voluntary insurance, while many of the plans originating in Washington lean toward the compulsory idea. The failure of the voluntary effort conducted in the ten counties, because of non-participation, undoubtedly will strengthen the hands of those wishing to force socialized medicine on the people.

"The editor of the Guide would be glad to receive the comments of Guide readers on any phase of the various proposals for medical and surgical care of the people, voluntary or compulsory socialized. Send to Guide editorial offices, Acton, Indiana."

CONGENITAL CATARACT AND GLAUCOMA

Family histories in a number of these cases have disclosed the occurrence of German measles in the mothers during the first three months of pregnancy. Usually such cases have been classified as sporadic where no history of heredity could be obtained. Further studies may implicate other virus diseases.

QUALIFICATION REQUIREMENTS OF APPLICANTS FOR CERTIFICATION BY THE INDIANA BOARD OF GENERAL PRACTICE OF MEDICINE

Each applicant for admission to the examination is required to present evidence that he has met the following standards:

1. Satisfactory moral and ethical standing in the profession.
2. Membership in his local county medical society.
3. Graduation from a medical school recognized by the Council on Medical Education and Hospitals of the American Medical Association.
4. Completion of an approved internship, preferably of the general rotating type, in a hospital approved by the Council.
5. A citizen of the United States.
6. Present evidence of continuing his postgraduate education.
7. A minimum of five years of general practice after completion of a year of internship.
8. Application made on a blank for that purpose, and fee of fifty dollars for Founders, and twenty-five dollars for additional members.
9. The members of the Founders Group are to be selected from each councilor district. The basis of selection will be in direct proportion to the number of physicians practicing in that area. The final selection of these members will be based upon ability and experience justifying Certification in the Founders Group.
10. Members of other Certifying Boards will not be eligible for membership on this Board.
11. In exceptional instances the Board may accept for examination outstanding candidates who have been in practice prior to January 1, 1930, but whose formal training does not comply with the full preliminary requirements.

PROPOSED METHODS OF EXAMINATION

All applicants accepted for examination will be required to attain a passing grade in:

Part I. A review of case reports.
Part II. A written examination.
Part III. An oral clinical test.
Part IV. Demonstration of ability at the bedside and in the laboratory.

Candidates who successfully complete one part may proceed to the next.

Whenever an applicant fails to pass the examination, the Board, upon request, will make suggestions as to suitable courses of instruction for the purpose of overcoming deficiencies in the applicant's knowledge.

Part I.

The candidate must file fifteen case reports, in condensed form, for which he was personally responsible. These reports must be sufficiently complete so that the examiners can evaluate the judgment of the candidate in his choice of procedure. They are to include an analysis of each case with critical deductions derived from correctness or incorrectness of diagnosis, and of final results on discharge. This summary must include:

1. An account of the candidate's personal observation of the case.
2. The basis for diagnosis.
3. The facts which determined the course of treatment.
4. Critical conclusions to be drawn from the outcome of the case.

These case reports might cover a variety of material in one or more of the following fields: infectious diseases, including venereal and syphilis; deficiency diseases; diseases of metabolism; gastro-intestinal tract; respiratory system; kidneys; blood-forming organs; circulatory system; glands of internal secretion; nervous system; bones, joints, and muscles; obstetrics; pediatrics; dermatology; neuropsychiatry; office gynecology; surgery; and allergy.

Part II.

A comprehensive written examination, including questions of the basic medical sciences and subjects pertaining to the General Practice of Medicine, bearing in mind the quality and extent of knowledge necessary to be a first class general practitioner.

Part III.

This part consists of an oral examination directed to ascertain the candidate's familiarity with recent medical literature, the breadth of his clinical experience, his capabilities, general adaptability, diplomacy, and his general qualifications.

Part IV.

Another part of the oral examination is conducted at the bedside and in the laboratory. Each candidate will be assigned one or more patients in the hospital, that he may demonstrate his approach and handling of a new patient.

INDIANA PHYSICIANS RELEASED FROM SERVICE

Medical Corps Officers Separated from Active Duty

(This is a continuation of the lists published in the October, 1945, January, 1946, and March, 1946, issues of THE JOURNAL.)

ADAMS COUNTY

Zwick, Harold F.——Decatur

ALLEN COUNTY

Appel, William——Fort Wayne
Chambers, Alan R.——Fort Wayne
Emme, Richard W.——Harlan
Ferguson, Arthur N.——Fort Wayne
Gerding, William J.——Fort Wayne
Gladstone, N. H.——Fort Wayne
Hasewinkle, August M.——Fort Wayne
Hattendorf, Anton P.——Fort Wayne
Lenk, George G.——Fort Wayne
McCabe, Theodore E.——Fort Wayne
Miller, Richard H.——Fort Wayne
Nahrwold, Elmer W.——Fort Wayne
Popp, Milton F.——Fort Wayne
Stier, Paul L.——Fort Wayne
Uhrick, John H.——Fort Wayne
Wilkins, Robert W.——Fort Wayne
Williams, Aubrey H.——Fort Wayne
Wilson, Leslie——Fort Wayne

BARTHOLOMEW COUNTY

Ryan, W. J.——Columbus

BENTON COUNTY

Muller, Lullus P.——Boswell

BOONE COUNTY

Bailey, Lawrence S.——Zionsville

CARROLL COUNTY

Gros, Hubert——Delphi

CASS COUNTY

Bailey, Earl W.——Logansport
Newcomb, William K.——Royal Center

CLARK COUNTY

Goodman, Eli——Charlestown

DAVIESS-MARTIN COUNTY

Rohrer, James R.——Elnora

DELAWARE-BLACKFORD COUNTY

Mulcahy, B. J.——Muncie
Owens, Richard R.——Muncie
Owsley, Guy——Hartford City
Scott, George E.——Hartford City

DUBOIS COUNTY

Heritier, Jules——Huntingburg

ELKHART COUNTY

Arlook, Theodore D.——Elkhart
Cormican, Herbert——Elkhart
Goodrum, William R.——Elkhart
Larkum, Newton W.——Elkhart

FLOYD COUNTY

Brown, Kenneth——New Albany

FULTON COUNTY

Herrick, Charles L.——Akron

GIBSON COUNTY

Geick, R. G.——Fort Branch

GRANT COUNTY

Davis, Joseph B.——Marion
Long, Max R.——Marion
Rhorer, John G.——Marion
Young, Robert G.——Marion

HANCOCK COUNTY

Arnold, Marion F., Jr. New Palestine
Hawk, Edgar A.——New Palestine

HENDRICKS COUNTY

Green, Charles E.——Plainfield

HOWARD COUNTY

Denton, L. D.——Greentown

HUNTINGTON COUNTY

Nie, Louis W.——Huntington
Omstead, Trevalyn——Andrews
Ware, J. Roger——Huntington
Woods, Holden C.——Markle

JOHNSON COUNTY

Jones, Charles A.——Franklin

KNOX COUNTY

Shaffer, Kenneth L.——Vincennes

LAKE COUNTY

Dainko, Alfred J.——Whiting
Nelson, Richard B.——Hammond
Parker, John T.——Gary
Rendel, Donald T.——Hammond
Rudser, Donald H.——Whiting
Slaughter, Earl C.——Hammond
Swets, Edward J.——Hammond

LAPORTE COUNTY

Daley, Edward H.——LaPorte
Ruff, Carl H.——LaPorte

LAWRENCE COUNTY

McClure, David N.——Bedford
Wohlfeld, Julius B.——Bedford

MADISON COUNTY

Aagesen, Walter J.——Anderson
Larmore, Joseph L.——Anderson
Reed, Roger R.——Anderson
Van Ness, William C.——Summitville

MARION COUNTY

Albright, Victor F.——Indianapolis
Aronson, Sidney——Indianapolis
Boyer, Edward B.——Oaklandon
Brill, Israel W.——Indianapolis
Britton, W. D.——Indianapolis
Bryan, Franklin A.——Indianapolis
Clouse, Paul A.——Indianapolis
Cornacchione, Matthew Indianapolis
Dintaman, Paul G.——Indianapolis
Dorman, Jack——Indianapolis
Earhart, Henry T.——Indianapolis
Ferguson, William B.——Indianapolis
Firestein, Roy——Indianapolis
Godwin, J. David——Indianapolis
Haggard, Edmund B.——Indianapolis
Holman, Jerome E., Jr.——Indianapolis
Jay, Arthur N.——Indianapolis
Lamber, Chester K.——Indianapolis
Ling, John F.——Indianapolis
Lester, Louis J.——Indianapolis
McTurnan, Robert W.——Indianapolis
Owen, John E.——Indianapolis
Pandolfo, Harry——Indianapolis
Pearce, Roy V.——Indianapolis
Poland, Maynard F.——Indianapolis
Reiss, Jack——Indianapolis
Row, D. Hamilton——Indianapolis
Salb, Max C.——Indianapolis
Sparks, Alan L.——Indianapolis
Tischer, E. Paul——Indianapolis
Travis, Julius C., Jr.——Indianapolis
Walther, Joseph E.——Indianapolis
Wayne, Charles M.——Maywood
Westfall, B. Kemper——Indianapolis

MIAMI COUNTY

Horsman, Russell R.——Miami

MONROE COUNTY

Holland, Philip T.——Bloomington
Poland, Maynard F.——Bloomington
Schell, Harry D.——Bloomington

PARKE-VERMILLION COUNTY

Harstad, Casper——Rockville

PIKE COUNTY

Omstead, Milton——Petersburg

PUTNAM COUNTY

Veach, Richard L.——Bainbridge

RANDOLPH COUNTY

Stoelting, Vergil K.——Winchester

ST. JOSEPH COUNTY

Bershadasky, Sol——Mishawaka
Blackburn, Erwin——South Bend
Caton, Joseph R.——South Bend
Clark, William H.——South Bend
Rosenwasser, Jacob——Mishawaka
Zimmer, Henry J.——Mishawaka

TIPPECANOE COUNTY

Buhrmester, Harry C.——Lafayette
Graham, Thomas G.——Lafayette
Harris, Lloyd E.——Lafayette
Neumann, Kenneth O.——Lafayette
Ratcliff, Frank W.——Lafayette

VANDERBURGH COUNTY

Hare, Daniel M.——Evansville
Moran, Thomas J.——Evansville
Strough, L. C.——Evansville

VIGO COUNTY

Goodman, Hubert T.——Terre Haute
Silverman, Norman M.——Terre Haute

WABASH COUNTY

Mills, John F.——Wabash

Military News

Major Kenneth Wilhelmus, of Newburg, was discharged recently after three and one-half years in the Medical Corps, and has resumed his practice.

Dr. Hubert Gros, a major in the Army Medical Corps before being discharged after four years of service, has returned to Delphi to practice medicine. He served overseas in India.

On duty at hospitals in Sioux Falls and El Paso for more than three and one-half years, Lieutenant Colonel H. C. Buhrmester, of Lafayette, is now on terminal leave.

On terminal leave after forty months overseas, Dr. Don E. Kelly has returned to private practice in Indianapolis. He served in Africa and Sicily, and held the rank of major.

Separated from the service at Fort Sheridan recently, Lieutenant Colonel Lowell R. Stephens, of Covington, has resumed his medical practice. For a year and a half he was the medical doctor in charge at Fort Knox, Kentucky.

Leo R. Nonte, M.D., of Indianapolis, has returned after twenty-eight months overseas. Doctor Nonte was on duty with the 58th Evacuation Hospital, first on ward service, then on the general surgical service. He has the Asiatic-Pacific ribbon with three stars, the Philippine Liberation ribbon with two stars, and the Bronze Star Medal.

After being discharged from the Army Medical Corps, Captain Earl W. Bailey has returned to Logansport to resume practice. Doctor Bailey was with the 93rd Station Hospital in Africa, later being stationed at various hospitals in the United States. He was in service a total of forty-two months.

After three and one-half years' service in the United States Army, Captain Carl J. Schneider, of Indianapolis, has resumed his private practice there. Doctor Schneider entered the service in 1942, and had charge of dependent clinics at Barksdale Field, Louisiana, and MacDill Field, Florida.

Lieutent Colonel Herbert L. Sedam, of Indianapolis, who entered the Army in January, 1941, has returned to private practice in Indianapolis. Doctor Sedam served with the 91st Evacuation Hospital, and was awarded five battle stars. He was chief of a general surgery group in North Africa, Sicily, England, France, Holland, and Germany, and served overseas for thirty-two months.

Commander Erwin Blackburn has recently returned from duty with the Third Fleet, and will resume his practice in South Bend.

Dr. Larkin D. Denton, who recently returned to Greentown after considerable service, has opened an office and is now engaged in the general practice of medicine.

Following more than three years of Army duty, Dr. Ernest R. Beaver has returned to Rensselaer to practice medicine. Doctor Beaver went overseas in August, 1943, serving as chief of the Orthopedic Section in a station hospital in England.

A veteran of more than two years' service in Europe, Dr. Robert W. McTurnan has now returned to civilian practice in Indianapolis. Doctor McTurnan served as a captain with the First Army, and holds five battle stars.

Dr. James T. Oswalt, of Brazil, who went overseas just two months after he entered service, has returned home and resumed civilian practice. Doctor Oswalt served overseas for forty-one months with the 117th Station Hospital in the Asiatic-Pacific Theatre.

As an allergist, Major Simon S. Rubin, of Gary, found his work in that field greatly diminished during his seventeen months' stay in Iceland, where there is no vegetation and therefore no hay fever. Doctor Rubin was on duty as assistant sector surgeon. He has returned to practice at his former location.

After forty-five months in the armed forces, Dr. Elmer W. Nahrwold, of Fort Wayne, has returned home. The first three years were spent in general surgery at Truax Field, Madison, Wisconsin, and the last nine months of his service was at the Headquarters of the Army Air Forces Technical Training Command, in St. Louis, Missouri. Doctor Nahrwold served with the rank of major.

Formerly of Indianapolis, Dr. L. P. Muller has opened offices in Boswell for the practice of medicine, since his release from active service. Doctor Muller served with the rank of major. He served overseas in Africa, Italy and France as medical officer with the 638th Medical Clearing Company, and also as battalion surgeon with the 1330th Engineer General Service Regiment in the Asiatic-Pacific area.

Almost four years of duty with the Navy was ended for Dr. L. S. Bailey, of Zionsville, on March third, when he arrived home on terminal leave.

On terminal leave, Dr. Jacob Rosenwasser, of Mishawaka, has reopened his office there. He was in the Army four years, and served overseas in Italy, Sicily, and North Africa.

Recently released from Army service, Dr. Louis W. Nie has returned to Indianapolis to resume his duties at the City and Indiana University Hospitals. Doctor Nie was on duty as a psychiatrist at the Cleveland Induction Center.

Major Kenneth H. Brown, of New Albany, has recently reverted to inactive status, and plans to resume practice in New Albany. Entering the Army in 1942, Major Brown served as medical officer of the regional hospital at Camp Polk, Louisana, until he was released.

For outstanding achievement in typhus control work in the European war area, including his work at the infamous Dachau Concentration Camp in Germany, the United States of America Typhus Commission Medal has been awarded to Dr. Glen V. Ryan, of Indianapolis. Dr. Ryan, who was the head of a typhus control team in the 7th Army, has recently been released from active duty and has returned to private practice. He held a captaincy.

On duty with the 2nd Division Marines at Saipan and Okinawa for eighteen months, Dr. John Kenneth Jackson, of Aurora, has recently returned to the United States. In August, 1944, Doctor Jackson was made surgeon for the 6th Division Marines; he went with the invasion forces to Nagasaki, and remained there until he returned to the United States. Doctor Jackson left the service with the rank of lieutenant commander.

Following his recent discharge from the Army, Major L. B. Chambers has returned to Union City. Major Chambers was first stationed at several Army air bases in California, then was assigned to the *U.S.A.H.S. Thistle*. He was stationed there for six months, three months in the surgical service, and three as commanding officer. Major Chambers was discharged when the ship was decommissioned.

After twenty-two and one-half months in the Pacific theatre, Captain Hugh K. Thatcher, Jr., of Indianapolis, has resumed his practice at his former location in Indianapolis. Doctor Thatcher served as chief of surgery of the 54th General Hospital in Tokyo, and he holds the Asiatic-Pacific ribbon, with two campaign stars, the American Theatre Ribbon, and the Philippine Liberation ribbon, with a bronze star.

Major William H. Clark has been released from medical duty with the Army Air Force, and plans to resume practice in South Bend.

According to a recent announcement, Dr. Jerome A. Graf, of Bloomfield, has opened offices for the private practice of medicine. Doctor Graf served four years and four months in the Army Medical Corps, twenty-three of which were spent at a station hospital serving Air Corps personnel in England.

Major Thomas G. Graham has returned to Lafayette to resume his private practice of medicine. Major Graham is now on terminal leave after having served in the Pacific area for forty-five months. He served in Australia, New Guinea, Bougainville, the Admiralty Islands, and Luzon.

Notice of his promotion to colonel has recently been received by Dr. E. E. Mason, of Evansville. The promotion coincided with the termination of active duty after long service in North Africa, Italy, and Europe. Doctor Mason was commander of the 58th Medical Battalion with the Seventh Army when the war ended.

Dr. Sidney S. Aronson has returned to practice in the Hume Mansur Building, in Indianapolis, after serving as a lieutenant colonel in the Army Medical Corps for three and one-half years. Doctor Aronson was stationed at the Army Air Force Flying School at Smyrna, Tennessee.

Dr. David Hadley, of Indianapolis, was awarded the bronze star for going to an ambushed Signal Corps group and giving first aid, and for helping to rescue two airmen from a fallen plane and giving them first aid. Following his discharge from service, Doctor Hadley is now a resident at the City Hospital.

After more than three years in the service, Lieutenant Colonel Howard E. Hill, of Muncie, has returned to private practice. Colonel Hill entered the service August 14, 1942, and was stationed at the Chicago Radio Schools; at Randolph Field, Texas; Gulfport, Mississippi; and Nashville, Tennessee. He served as base surgeon at Sioux Falls, Iowa. He is now on terminal leave.

At the time of his discharge, Dr. J. R. Logan, of Evansville, then a major, was serving as chief of surgery and orthopedics at Fort Story Station Hospital at Virginia Beach, Virginia. During the war he was ship surgeon to Alaska and the Aleutian Islands for almost a year, and was in the invasion of Attu. While stationed near Alaska, Doctor Logan took part in the rescue of one hundred men when a Liberty ship broke in two during a severe storm. Doctor Logan has returned to practice.

On duty for forty-four months with the Army Medical Corps, Major Dee Dar Gill, of Greenfield, has been discharged. Major Gill was stationed at hospitals in Texas and Florida, and elsewhere.

Now on terminal leave, Dr. Matthew Cornacchione, who served with the rank of lieutenant colonel in the Army Medical Corps for more than three years, plans to renew his practice in Indianapolis. Doctor Cornacchione was chief of the Surgical Service at Baer Field, Fort Wayne, going from there to the Percy Jones General Hospital, at Battle Creek, Michigan, as assistant chief of the general surgical section.

Commander Wesley Merle Hoppenrath has resumed his practice in Elwood, following his recent discharge from the Navy. Doctor Hoppenrath entered the service in December, 1942, and left for overseas duty in April of 1945, where he served in the China-Burma Theatre. He also served as surgeon abord the *USS Laertes* in the Pacific. For several months he was stationed in the Marshall Islands.

In February, 1941, Lieutenant Colonel Joseph O. Flora, of Indianapolis, entered the Army Medical Corps, and has now been released. The following summer he went to Kodiak, Alaska, with the 201st Infantry, and then to Adak and Amchitka in the Aleutians. Colonel Flora's definition of the Aleutians was that they were just a lot of nothing, with plenty of mud. In March, 1944, he returned to Camp Carson, Colorado, and then later went to the Panama Canal Zone, which he says was the nicest trip he had.

Major Kenneth L. Shaffer, of Vincennes, plans to reopen his office in Vincennes in the near future, following his recent release from the Army Medical Corps. Doctor Shaffer entered the service on July 5, 1942, and was in the Army Air Corps Air Transport Command for thirty-one months. He also served as flight surgeon. For the past twelve months he has been with the Sixth Service Command at the Percy Jones Hospital Center, at Fort Custer, Michigan, and Fort Sheridan, Illinois.

One of the first doctors to be called into service, Major Opal L. Wood, of Brazil, has announced the resumption of his private practice there, following his recent release from the service. Entering the service in March, 1941, Doctor Wood served in the Army Medical Corps for three years in the United States and for two years overseas in the European Theatre. He was assigned to the Combat Engineers and was in command of a Medical Battalion, and later supervised sixty German Military Hospitals. Doctor Wood's ETO service ribbon bears five combat stars, representing duty in Normandy, Northern France, Ardennes, Rhineland, and Central Europe.

After five years of duty, Dr. Walter J. Aagesen has been released from service and has opened an office in Anderson. Doctor Aagesen was discharged with the rank of lieutenant colonel. He served for four and one-half years as chief of the EENT service at the Army's largest general hospital—the Lovell General Hospital, at Fort Devens, Massachusetts, which has a six-thousand bed capacity.

A Terre Haute physician, Major Hubert T. Goodman, has returned from China, and has been discharged from the Army. He went to China in August, 1943, where he was given a medical assignment in the Y Force which was active in the Salween campaign against the Japanese. He was later transferred to the Chinese Training Center. Doctor Goodman has reopened his office for private practice.

Dr. M. S. Mount, of Bloomfield, has reopened his offices after serving for three and one-half years in the Army Medical Corps. Doctor Mount went overseas on April 1, 1944, with a Tank Destroyer Battalion, later being transferred to the 249th General Hospital at New Guinea, where he was assigned as assistant chief surgeon. With this unit he went to the Philippines, and remained there until his return to the United States. At the time of his discharge from the Medical Corps he held the rank of major.

Another Indiana physician to be honored by being awarded the Legion of Merit is Lieutenant Colonel Milton W. Erdle, of Frankfort, for exceptionally meritorious service as an Army Air Forces post surgeon in the United Kingdom from August 11, 1943, to December 8, 1944. In southern England, during intense V-bomb attacks in 1944, Colonel Erdle devised special equipment and organized and trained special medical-surgical teams which cared for American casualties of these bombings, and also rendered assistance to British officials in caring for civilian casualties. Doctor Erdle has now been relieved from active duty.

Captain Jerome E. Holman, Jr., of Indianapolis, is another physician who has returned from service and who will begin the private practice of medicine soon. Doctor Holman entered service December 31, 1943, and went overseas with the 95th Medical Gas Treatment Battalion, with which he served in England, France, Belgium, Holland, and Germany. He informs us that he was waiting at Marseilles, France, to be shipped to the Pacific when the war ended. Doctor Holman has battle stars for the Northern France, Rhineland, and Central Europe actions. After his return to Indianapolis, he was attached to the 836th Specialized Depot, at the State Fair Grounds, in Indianapolis. He is now on terminal leave.

Having gone into service upon completion of his internship, Captain William B. Ferguson, of Indianapolis, has returned and is now on terminal leave. He entered the service in December, 1943, and first went to Carlisle Barracks, in Pennsylvania, then to the Walter Reed General Hospital, in Washington, D. C., as a part of his training, and next went to Camp Stewart, Georgia, where he was assigned to the 843rd Anti-Aircraft Battalion, with which he went overseas, landing in Bombay, India, in August, 1944. In November, 1944, Doctor Ferguson was transferred to the 14th Air Force, as base surgeon, and went to Burma, then to Chengtu, China, where he remained for fifteen months. Following this, he skipped around from Chungking, to Hankow, and then to Shanghai. While in China, he operated a twenty-five bed dispensary, and before leaving assisted in inoculating the Chinese Sixth Army. He plans to enter practice somewhere in Indiana.

Major Fred L. Wilson, of Terre Haute, after three and one-half years in the service, has reopened his office for the private practice of medicine. Doctor Wilson was commissioned a Captain on June 12, 1942, and was first stationed at Patterson Field, Ohio, where he was assigned to the Army Air Force Station Hospital, in charge of communicable diseases, and later as cardiologist. On September 1, 1943, he was transferred to Springfield, Illinois, where he was commanding officer of an Army Air Force Station Hospital. Due to overseas movement of troops, this hospital was closed in January, 1944, and he was transferred to Camp Reynolds, Pennsylvania, where he served as an internist and medical consultant. In December, 1944, Doctor Wilson was transferred to Indiantown Gap, Pennsylvania, where he was assigned to the station hospital as chief of the cardiovascular section as medical consultant, and later became assistant chief of the Medical Service. He was placed on inactive duty on December 13, 1945.

Among the Terre Haute physicians returning from long service is Dr. Don M. Mattox, who began active duty with the Navy Medical Corps in July, 1942. He served with the Naval beach party during the initial invasion of North Africa, and for his work during this assault was awarded the coveted Legion of Merit. The next eighteen months were spent as transport surgeon aboard an assault transport. During this duty he participated in the invasions of Sicily and Salerno. Then he returned to the United States and was stationed for a year at the Naval Hospital at Memphis, Tennessee, doing general and reconstructive surgery in addition to being in charge of the gynecological service. In March, 1945, he began a second tour of sea duty aboard a new assault cargo ship, and spent the last three weeks of the war at Okinawa. While in Korea he became eligible for discharge and returned to civilian life on January first.

Following his terminal leave from the United States Army, Captain F. K. Allen, of Fredericksburg, has located in Salem to begin the practice of medicine. Doctor Allen entered the armed forces in July, 1942, with the Amphibian Engineers, and following training in the United States served for thirty-one months in the South Pacific Theatre.

Another Indianapolis physician who has returned to private practice is Lieutenant Commander James H. Hawk, who was discharged from the Navy in December. Doctor Hawk entered the Navy in April, 1942. He was in charge of the family hospital at Quantico, Virginia, with an LST hospital ship with the Seventh Fleet in the South Pacific, and at a naval base at Subic Bay, in the Philippine Islands. He holds the Asiatic-Pacific Theatre ribbon, with one battle star, and the Philippine Liberation ribbon, with one star.

Colonel Guy A. Owsley, M.C., former chief of the Eye, Ear, Nose, and Throat Section, and later Executive Officer, Billings General Hospital, was separated from service at Fort MacArthur, California, on March 15, 1946, after five years of active duty.

Colonel Owsley assumed command of the Army Hospital Ship *Emily H. M. Weder* on March 1, 1944, and served in both theatres of operation. After the ship was decommissioned in October, 1945, he was placed in command of the Station Hospital, Los Angeles Port of Embarkation, serving also as port surgeon of the Los Angeles Port for the past few months.

Colonel Owsley is now doing graduate work in Otology at the Los Angeles General Hospital, under the direction of Dr. Howard House, a former Hoosier. On completion of the work he will resume practice in Indiana.

The Legion of Merit has been awarded Dr. Donald A. Covalt, of Muncie, for his services with the Army Air Forces. Doctor Covalt received a citation which read: "As convalescent training officer, Army Air Forces Hospital, Miami Beach Training Base, and later, as executive officer of the Convalescent Services Program, office of the Air Surgeon, during the period from April, 1943, to November, 1945, Colonel Covalt rendered outstanding service of tremendous value to the Army Air Forces Medical Department and the military service at large. The Convalescent Services Program which Colonel Covalt organized and directed became a model for the Army Air Forces, and the experience of this project was utilized by other branches of the service and by the military services of our Allied nations." Doctor Covalt is now the assistant medical director of Medical Rehabilitation of the Veterans Administration. He formerly practiced in Muncie with his wife, Dr. Nila Covalt, who continued her practice there until this year, when she left for Washington to join her husband.

News Notes

After forty-two years in the general practice of medicine, Dr. J. H. P. Gauss, of Indianapolis, retired on April first.

Miss Jane Gardner and Dr. David M. Jones, both of Indianapolis, were married on March twenty-third in the Sweeney Chapel at Butler University. The bride is a student nurse at the Indiana University Medical Center, and Doctor Jones is a resident in pediatrics at the James Whitcomb Riley Hospital, having graduated from the Indiana University School of Medicine in 1943.

Dr. D. Hamilton Row, of Indianapolis, and Mrs. Alice Grace Rhodes, of Washington, D.C., were married in the chapel of the Navy Air Field Receiving Station, in Washington, on March sixteenth. They are at home in Indianapolis. Dr. Verne K. Harvey, formerly of Indianapolis, was the best man. Doctor Row served more than three years in the Navy and was released as a commander. He entered the service at Great Lakes, and served there and at the Naval Dispensary in Washington, D.C., until he left service. He has returned to practice at his former location.

CLASS REUNIONS

Prior to the war it was a pleasant custom to hold class and fraternity reunions during the annual meeting of the Indiana State Medical Association. These meetings were discontinued during the war emergency. It is enthusiastically hoped that these reunions will be reinaugurated at the next and succeeding state meetings.

Will those in charge of their classes and fraternities, who are desirous of holding such reunions, please notify Dr. J. W. Hendricks, 911 Hume Mansur Building, Indianapolis, Indiana?

WHAT IS YOUR FAVORITE SPORT?

This year's state meeting of the Indiana State Medical Association undoubtedly will be the largest in its history.

Let's make the Golf and Trap Shoot Tournaments the largest, too.

Plan now to take part in our chosen sport on Tuesday, October 29. At least for one day we can forget telephones, night calls, strikes, state medicine, and get together to have fun and win prizes.

Time and place for each event will be announced later.

CONVENTION SPORTS COMMITTEE.

After extensive postgraduate work in surgery at the University of Pennsylvania, Dr. T. R. Colman, a graduate of the Medical School of the University of Louisville, has become associated with Dr. George A. May, in his offices at Madison.

MR. PALMER REPLACES MR. SMITH

Mr. Joseph E. Palmer, of Wabash, Indiana, was chosen executive secretary of the Indianapolis Medical Society, to succeed Mr. Ray E. Smith, who in turn became full-time secretary of the Indiana State Medical Association on May first.

Mr. Palmer is a native of Wabash, and has served on the staff of several Indiana newspapers and later as a member on the staff of the Chicago office of the Associated Press prior to his entry into the Army in World War II, during which time he served in the European Theatre of Operations in the field of public relations.

Dr. John T. Kime, of Petersburg, recently celebrated his fifty-seventh anniversary of service as a physician in that city. Both Doctor Kime and Dr. T. R. Rice, of Petersburg, have served continuously for more than fifty years, and they have at some time held all the medical offices in Pike County.

Dr. J. E. Ferrell, of Fortville, president of the Indiana State Medical Association, and Dr. E. Vernon Hahn, of Indianapolis, president of the Indianapolis Medical Society, have appointed Dr. Gordon W. Batman, of Indianapolis, as general chairman of the Arrangements Committee for the annual meeting of the Indiana State Medical Association, to be held in Indianapolis on October 29, 30, and 31, 1946.

Dr. Batman's committee has been appointed and has met to make initial plans. The sub-committee chairmen are:

Assistant General Chairman: Dr. Brandt F. Steele.
Instructional Work: Dr. Russell A. Sage.
Annual Banquet: Dr. Ben B. Moore.
Smoker and Luncheon Menus: Dr. C. E. Cox.
Sports Program: Dr. Russell R. Hippensteel.
Reception Committee: Dr. James N. Collins.
Entertainment: Dr. C. F. Thompson.
Organization Luncheons: Dr. J. W. Hendricks.
Women's Physician's Banquet:
    Chairman: Dr. Martha Souter.
    Vice-chairman: Dr. Mary Alice Norris.
Budget Director: Dr. J. W. Ricketts.
Women's Auxiliary Affairs:
    Chairman: Mrs. John Carmack.

Commander Frank M. Hall, of Indianapolis, recently returned from service, has been named medical consultant of the Division of Vocational Rehabilitation and the Blind, of the State Department of Education.

Drs. Thomas J. Senese, of Gary, and Dr. C. N. Combs, of Terre Haute, have been named as medical members of an advisory committee to assist in planning increased hospital facilities in Indiana; this committee recently having been appointed by Governor Gates. The committee represents professional, industrial, argricultural, and labor groups.

Dr. George D. Davis, of Indianapolis, who recently returned from the armed forces, began serving a two-year Fellowship in Radiology at the Mayo Clinic on April first.

NOTICE NEW ADDRESS!

The Indiana State Board of Medical Registration and Examination has moved its headquarters from the state house to 627 K of P Building, Indianapolis.

ERRATA!

On page 163, column 1, line 10 of the April, 1946, issue of THE JOURNAL of the Indiana State Medical Association the word "uncomplicated" was inadvertently used instead of the word "complicated."

RADIO CALENDAR

"YOUR HEALTH IN WARTIME"

Hear these broadcasts each week:

Indiana State Medical Association — "Ladies, Your Health!"—Monday, 2:45 P.M., WFBM, Indianapolis

Vigo County Medical Society — Thursday, 12:15 P.M., WBOW, Terre Haute.

St. Joseph County Medical Society — Friday, 1:45 P.M., WSBT, South Bend.

HISTORICAL DATA INVITED

Plans of the Centennial Celebration Committee of the Indiana State Medical Association include the preparation of a book on "The History of Medicine in Indiana."

To make it an accurate and comprehensive panorama of developments from wilderness days to date, state-wide help in the form of suggestions and source information will be welcomed by the committee. Many phases have already been the subject of research work. It is hoped that a volume acknowledging and correlating these efforts will prove most worth while.

Mrs. Dorothy Russo has been engaged to assist in the compilation. Any person having historical information of value is urged to write to her at 2135 North Alabama Street, Indianapolis 2, Indiana.

PLACEMENT SERVICE FOR PHYSICIANS IN INDUSTRY

In order to facilitate placement of qualified physicians, especially returning medical officers, in industrial medical service, the Council on Industrial Health of the American Medical Association, and the Committee on Industrial Health of the Indiana State Medical Association make the following recommendation to plant managers or others who are looking for medical personnel:

1. Attempt to fill the vacancy locally if possible. Consult the secretary of the county medical society or local academy of medicine for help and advice.
2. If local facilities are unavailable, apply to the secretary of the state medical association—his name and address can be secured from any physician. By taking these two steps first, an experienced physician licensed to practice in the area where the plant is located is most likely to be secured.
3. If neither of these procedures is productive, The Council on Industiral Health, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, is prepared to be as helpful as possible in bringing notice of vacancies or opportunities to the attention of physicians. Placement will be facilitated if some information is supplied about the nature of the plant, existing plant medical facilities, medical services desired, special medical qualifications necessary, and the salary rate.

In making application, physicians should supply the following data:

Name _____
Address _____
Medical School _____
Age _____
Telephone _____
Year Graduated _____
Licensure (Date and State) _____
Special Training _____
Experience in General and Industrial Medicine.

Doctor G. W. Wagoner, of Delphi, has been named county health officer for a four-year term, following his return from military service. Doctor Wagoner succeeds Dr. Charles L. Wise, of Camden.

Dr. Don F. Cameron, of Fort Wayne, was elected treasurer of the Northern Tri-State Medical Association by Indiana, Michigan, and Ohio doctors attending the meeting on April ninth, at South Bend.

Formerly a member of the Board of Trustees for many years, Dr. W. T. Lawson, of Danville, has given his medical library, consisting of more than sixty volumes, to the Central Normal College. Doctor Lawson, who is county health officer for Hendricks County, and the oldest practicing physician in Indiana, participated in the moving of the college from Ladoga to Danville in 1878, when it was actually moved by wagon.

PRECEPTORSHIPS

In regard to the substitution of a preceptorship for residency in an ophthalmic hospital, the American Board of Ophthalmology reports that it has always accepted such training in favorable cases. During the present overcrowding of facilities, the board expects to take a liberal attitude regarding the requirements for training.

"It should, however, be pointed out that neither a residency nor a preceptorship suffices in itself to meet the requirements of the board. Each case will still be judged on its merits in determining fitness for examination.

"In entering upon preceptorship, certain conditions should be kept in mind. First the student will profit most after a sound course in the basic sciences of physiology of the eye and of vision, optics, pathology, bacteriology, chemistry, pharmacology, and the relation of the eye to general disease, anatomy, embryology, and neurology.

"This is essential for a residency, more so for a preceptorship. While men have been accepted from preceptors not diplomates of the board, it is obvious that the board has more information about those teachers who have passed its examinations.

"Any preceptor should understand that he is assuming a responsibility in taking a student, and is not merely obtaining help in the drudgery of his office. He should be willing to give time to clinical training and the use of apparatus, slit lamp, ophthalmoscope, tonometer, and to directing the student's practice in surgery on animal eyes, assisting in operations, and ultimately in the performance thereof.

To cover the same amount of ground will take much longer in a preceptorship than in a residency, and students should accept opportunities to take hospital positions of all sorts as they become available."

INVITATION FROM INDIANA STUDY GUILD

A state dinner-meeting of the Indiana Study Guild will be held on June fifth at the Athenaeum, in Indianapolis, to which all members of the Indiana State Medical Association are cordially invited.

The membership of the Indiana Study Guild includes those surgeons who believe that education should be a perpetual avocation. The Study Guild meets this requirement and offers an opportunity to keep abreast with modern surgical technique and diagnosis. The Guild is an affiliate of the International College of Surgeons and meets once each month, at which time a prepared paper is read, and this is followed by an informal round-table discussion.

INDIANA UNIVERSITY NEWS NOTES

Specialists in otorhinolaryngology from twenty-one states and from the District of Columbia attended the annual two-weeks' postgraduate course at the Indiana University School of Medicine, April 15-26.

The course, popularly known as the Barnhill Course because of its establishment in 1915 by the late Dr. John F. Barnhill, of Indianapolis, was attended by a capacity number of forty specialists. It was conducted under the joint direction of Dr. C. H. McCaskey, chairman of the Department of Otorhinolaryngology, and Dr. E. N. Kime, chairman of the Department of Anatomy.

The course is the one postgraduate course of the university's medical school which has continued throughout the depression and through both world wars.

Indianapolis specialists were host to the visitors the evening of April fourteenth, at the traditional annual dinner, held at the Columbia Club, at which Dr. Frederick A. Figi, of the Mayo Clinic, spoke on "Tumors of the Nose and Throat." Guests included Dean W. D. Gatch, of the Indiana University School of Medicine; Dr. Claude Robison, president of the Indiana Academy of Ophthalmology and Otolaryngology; Dr. E. V. Hahn, president of the Indianapolis Medical Society, and Dr. J. E. Ferrell, president of the Indiana State Medical Association.

Convinced that the doctor of the future must have a broader background, the Indiana University School of Medicine curriculum committee plans to rearrange the pre-medical course requirements so as to place increasing emphasis on English, history, and other subjects commonly known as the humanities.

Command of the English language, ability to make a talk, and an education providing a broad view of life are among the needs in the pre-professional training of medical practitioners, in the opinion of Dean W. D. Gatch. The new course, however, will not be introduced at the expense of the essential basic science requirements.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

February 24, 1946

Roll call showed the following present: Cleon A. Nafe, M.D., chairman; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. M. Mitchell, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; Thomas A. Hendricks, executive secretary; and Ray E. Smith, assistant executive secretary.

Guests: Charles R. Bird, M.D.; chairman, Postwar Committee; C. F. Thompson, M.D., chairman, Veterans' Affairs Committee.

On motion of Dr. Mitchell, seconded by Dr. Romberger, Dr. Nafe was re-elected chairman of the Executive Committee for 1946.

Membership Report

Number of members, January 31, 1946	1960*
Number of members, January 31, 1945	1778
Gain over last year	182

* Includes 216 veterans, 400 in military service and 107 honorary members.

Number of members, December 31, 1945	3392

Statements of receipts and expenditures for December and January for the association committees and THE JOURNAL were approved.

Treasurer's Office

Question of salary increases for headquarters' staff discussed and referred to the Council.

Creation of special fund of $10,000, as directed by the Council at its November 1945 meeting, discussed.

Loans to veterans. This matter was presented by Dr. Bird, and suggested form to be used in making these loans was approved by the Executive Committee. The Indiana State Medical Association is to guarantee payment of loans up to $500.00. The borrower is to pay 3 per cent interest. The procedure for handling veterans' loans was approved upon adoption of a motion made by Dr. Romberger, seconded by Dr. Mitchell. Dr. Bird was instructed to write the Indiana National Bank through which these arrangements are being made. All loans arranged for are to be reported to the Executive Committee.

Headquarters' Office

Mr. Hendricks announced that the Board of Trustees of the American Medical Association desired him to become full-time secretary of the Council on Medical Service and Public Relations just as soon as it is convenient for him to be relieved of his duties in Indianapolis. This matter is to be placed before the Council for official action. The committee requested that his resignation not become effective until May 1. The committee recommended that the name of Ray E. Smith be presented to the Council at the April 14 meeting as Mr. Hendricks' successor.

1945 Annual Session, French Lick, Tuesday, Wednesday and Thursday, November 6, 7 and 8, 1945.

Duties placed on executive committee by House of Delegates and Council:

(a) Conference of state president with presidents of State Bar and State Dental Associations. Dr. Ferrell is to do this at his convenience.

(b) President is to appoint a Constitution Committee.

(c) Administrative chart to be prepared by the executive secretary and submitted to the Executive Committee before publication in THE JOURNAL.

1946 Annual Session, Indianapolis, Tuesday, Wednesday and Thursday, October 29, 30 and 31, 1946

Convention Arrangements Committee to be appointed by the president.

Commercial exhibit. Number of exhibits to be increased for 1946 meeting and floor plan and announcement to be sent out within the next month.

The committee approved the Murat Temple as headquarters for the meeting.

Legislative, Legal and Social Security Matters

National

Wagner-Murray-Dingell bill.

a. Hearings on this bill are to begin March 18.

b. Report made that Woman's Auxiliary is contacting delegates to the Y. W. C. A. convention where a resolution is to be introduced approving in principle the Wagner-Murray-Dingell bill.

Special committee on national legislation. The standing Committee on Public Policy and Legislation of the state association is to serve as the committee on national legislation which was suggested by the Council on Medical Service and Public Relations of the American Medical Association.

Prepayment Medical Plan

Report of progress on Indiana plan made by Mr. Stump.

National prepayment plan set-up discussed by Mr. Hendricks.

Letter concerning fee schedules for medical care of veterans in Cass County referred to the attorney of the association for reply.

Letter in regard to prepayment information from other states referred to Mr. Stump.

Letter from Indianapolis Accident and Health Club. The executive secretary reported that he had informed H. D. Davis, president of the Indianapolis Accident and Health Club, that it was too late to give consideration to this organization's proposal.

(continued on page xxx)

Excellence

resides in quality, not in quantity.

By
the *quality*
of its Defense
The Medical Protective Company
excels
in preserving
a Doctor's Reputation, Property and Earning Power
against Damage
from Malpractice charges



THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

(continued from page 264)

Suggestion made that editorial entitled, "Which Medical Plan Do You Farmers Favor?", in *The Farmers Guide,* be reprinted in THE JOURNAL.

Organization Matters

Membership of physicians remaining in military service. The question as to whether physicians who remain in military service after the war is declared over will receive a special concession in the payment of dues is to be referred to the House of Delegates.

Committee appointments.

(a) Dr. Ferrell is to appoint chairman of Committee on Mental Health.

(b) Dr. Mitchell is to appoint Committee on Secretaries' Conference.

Membership of retired and disabled physicians. Retired and disabled members who do not qualify for honorary membership in the state association due to age must pay the regular $5.00 a year subscription price for THE JOURNAL if they do not carry regular membership in the state association.

Conference of State Presidents. Question of Indiana joining Conference of State Society Presidents was postponed indefinitely. This action was taken upon the motion of Dr. Mitchell, seconded by Dr. Romberger. The president and president-elect were authorized to write the president of the Conference of Presidents to this effect.

War and Postwar Medicine

Fee schedules for medical care of veterans. Dr. Thompson explained that his committee had submitted the fee schedule of Michigan Medical Service, Inc., and the Veterans Administration schedule of fees to all county medical societies with the request that they submit a third proposed fee schedule for adoption in Indiana; that a composite schedule would be developed from those returned by the local societies for submission to the Veterans Administration, and the decision of the Veterans Administration on the items in the schedule would be presented to the Council on April 14 for confirmation or rejection.

Industrial Health Postgraduate Meeting

It was moved by Dr. Mitchell, seconded by Dr. Romberger, that the industrial health postgraduate meeting be postponed and that the suggestion be made to the Committee on Scientific Work that it book speakers on industrial health on the program for the annual session.

The Journal

Increase in assistant editor's salary for 1946 referred to the Council.

Mutual Benefit Health and Accident Association. The wording of the advertisement of the Mutual Benefit Health and Accident Association in THE JOURNAL was ordered changed in the event the ad is repeated, because it implies endorsement of the company by the Indiana State Medical Association.

Complaint against St. Paul Mercury Indemnity Company policy. The assistant executive secretary reported that an Indianapolis physician had complained that the policy of the St. Paul Mercury Indemnity Company permits settlement of cases out of court without the consent of the insured.

There being no further business the meeting was adjourned.

BUREAU OF PUBLICITY

March 4, 1946

Present: Ben B. Moore, M.D.; Thomas A. Hendricks, executive secretary; Ray E. Smith, assistant executive secretary and secretary of the bureau, and Mrs. Lotys Benning Stewart, publicity and script writer.

The following news releases for "Hints on Health," the column for weekly newspapers, were approved:

Week of March 11, 1946—"Facts About Sinus Infections."

Week of March 18, 1946—"The Common Cause of Constipation."

The following news releases for daily newspapers were approved:

"Watch Out for Appendicitis."

"Health Examination for Birthday Present."

"Nutrition and the New Bread."

Letter received from the director of the Indiana State Library, regarding instructions on release of medical records committed to his custody, was read.

Action upon request of the director of Health and Physical Education of the State Board of Health for a reprint of the bureau's leaflet on "Information Regarding the Prevention of Contagious Diseases" was postponed until the next meeting.

BUREAU OF PUBLICITY

March 18, 1946

Present: H. G. Hamer, M.D., chairman; Thomas A. Hendricks, executive secretary; Ray E. Smith, assistant executive secretary and secretary of the bureau, and Mrs. Lotys Benning Stewart, publicity and script writer.

The following news releases for "Hints on Health" were approved:

Week of March 25, 1946—"That Tired Feeling."

Week of April 1, 1946—"Causes of Nervousness."

The following news releases for daily papers were approved:

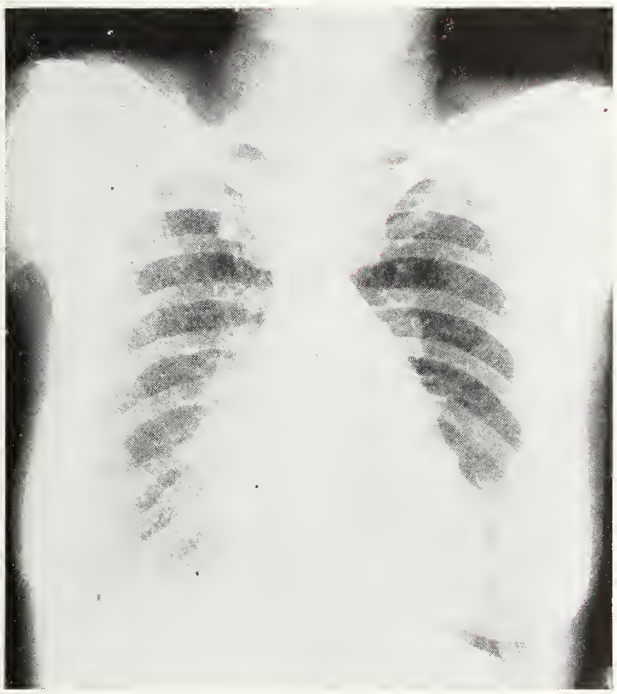
"Healthy Heart."

"Kidney Care."

A list of prospective speakers for the Ninth District Medical Society meeting at Lebanon, May 7, 1946, was compiled in response to a request from the program chairman.

Request of Vincennes physician for information on radio material available to the Knox County Medical Society was considered. The executive sec-

congestive heart failure



The de-edematizing action of Searle Aminophyllin decreases the cardiac burden, permitting the heart muscle to function more efficiently.

Searle Aminophyllin produces diuresis whether administered orally or parenterally, and thus has a field of usefulness covering emergencies and chronic congestive cardiac failure.

SEARLE AMINOPHYLLIN

contains at least 80% of anhydrous theophyllin.

G. D. Searle & Co., Chicago 80, Illinois

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

retary was directed to telephone the information to him.

The script writer was directed to prepare five five-minute scripts on voluntary health insurance for use on a Kokomo radio station, in response to a request from the Woman's Auxiliary of Howard County.

The folder on "Information Regarding the Prevention of Contagious Diseases" was ordered revised by state and city health authorities and reprinted, providing the State Board of Health would pay one-half the cost.

COUNTY SOCIETY OFFICERS

BENTON COUNTY MEDICAL SOCIETY
President, W. H. Altier, Fowler.
Secretary, L. P. Muller, Boswell.

CARROLL COUNTY MEDICAL SOCIETY
President, Max Adams, Flora.
Secretary-treasurer, C. L. Wise, Camden.

FULTON COUNTY MEDICAL SOCIETY
President, K. K. Kranning, Kewanna.
Vice-president, D. K. Stinson, Rochester.
Secretary-treasurer, A. E. Stinson, Athens.

HAMILTON COUNTY MEDICAL SOCIETY
President, Oscar D. Havens, Cicero.
Vice-president, F. P. McDaniel, Atlanta.
Secretary-treasurer, Robert F. Harris, Noblesville.

MIAMI COUNTY MEDICAL SOCIETY
President, Fred Malott, Converse.
Vice-president, S. D. Malouf, Peru.
Secretary-treasurer, R. E. Barnett, Peru.

ORANGE COUNTY MEDICAL SOCIETY
President, John K. Spears, Paoli.
Secretary, C. E. Boyd, West Baden Springs.

TIPPECANOE COUNTY MEDICAL SOCIETY
President, E. T. Stahl, Lafayette.
Vice-president, H. H. Ash, West Lafayette.
Secretary, J. C. Burkle, Lafayette.
Treasurer, Charles Hupe, Lafayette.

LOCAL SOCIETY REPORTS

Bartholomew County Medical Society members held a meeting on March twenty-seventh, at the Noblitt-Sparks Cafeteria, in Columbus. Sixteen members were present.

Delaware-Blackford County Medical Society members met at Hotel Roberts, in Muncie, on March nineteenth, when Dr. O. E. Spurgeon, of Muncie, spoke on "Mechanical Respirators in the Hands of Laymen." Twenty-three members were present.

Elkhart County Medical Society members met at Hotel Elkhart, in Elkhart, on April fourth, when the forty-nine members present heard Dr. Paul S. Rhoads, of Evanston, Illinois, discuss "The Management of the Various Pneumonias."

Fayette-Franklin County Medical Society members met at the McFarlan Hotel, in Connersville, on April ninth. Nine members were present.

Floyd County Medical Society members met at the Country Club, in New Albany, on April twelfth. Dr. P. M. Davis, of New Albany, discussed "The Treatment of Malaria." The twenty-three members present also held a discussion on medical economics problems.

Greene County Medical Society members held a regular business meeting on March fourteenth, at the Freeman Greene County Hospital, in Linton. The thirteen members present discussed hospital problems. At a meeting on April eleventh, at the Freeman Greene County Hospital, in Linton, Mr. Albert Stump, of Indianapolis, spoke on the "Medical Prepayment Plan." Sixteen members attended.

Indianapolis (Marion County) Medical Society members held a meeting on April ninth at the St. Vincent Hospital Nurses' Home, in Indianapolis. Papers read at this meeting were: "Report of Case of Histoplasmosis," by Dr. William E. King, of Indianapolis; "Latent Phlebitis," by Dr. Clark Day, of Indianapolis; and "Office Management of Diabetes Mellitus," by Dr. Raymond E. Mitchell, of Indianapolis.

At a meeting on April sixteenth, Dr. Karl A. Meyer, of Chicago, Illinois, gave a lecture.

On April twenty-third, another meeting was held, when Dr. Wayne L. Ritter, of Indianapolis, discussed "Industrial Toxicology," and Dr. Harold M. Trusler, of Indianapolis, spoke on "Neoplasma of the Head and Neck."

On April thirtieth, Dr. Ernest Rupel, of Indianapolis, presented "Bladder Trouble—Practical Office Management," and Dr. Paul K. Cullen, of Indianapolis, discussed "Mobile Cecum and Redundant Cecum As Clinical Entities."

Lake County Medical Society members met at the Indiana University Extension Center, in East Chicago, on March fourteenth. "New Hospital Facilities" were discussed by Dr. T. J. Senese, of Gary. The forty-five members present also discussed the Veterans' Care Plan.

LaPorte County Medical Society members held a meeting on March twenty-first, at St. Anthony's Hospital, in Michigan City. The guest speaker was Dr. F. R. N. Carter, of South Bend, whose subject was "Relations Between Health Officer and the Community." Fifteen members attended the meeting.

Montgomery County Medical Society members met at the Culver Hospital, in Crawfordsville, on March twenty-first. Dr. David A. Boyd, Jr., of Indianapolis, presented a paper on "Psychosomatic Medicine." Members and guests numbered twenty-seven.

A NEW CEREAL FOR

Infants and Children WITH PAPAYA FRUIT

DRIED FRESH TO PRESERVE NATURAL ENZYMES AND PECTINS

Cerol

•Reg. U. S. Pat. Off



THE LATEST ADDITION to the famous S. M. A. Infant Foods —CEROL . . . something new in infant feeding—FLAVORED . . . with mellow papaya fruit—FORTIFIED . . . with vitamins and minerals — READY TO SERVE . . . a nutritious, precooked, multigrain cereal—Supplied in 8 oz. packages.

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S. M. A. DIVISION • WYETH INCORPORATED • PHILADELPHIA 3 • PA.

Putnam County Medical Society members held a meeting in Greencastle, on March fourteenth, when the eleven members present discussed local problems.

Randolph County Medical Society members met in Winchester, on April eighth. The guest speaker was Dr. C. R. Slick, of Lynn, whose subject was "Venereal Disease Control." Ten members were present.

Tippecanoe County Medical Society members held a meeting on April ninth, at the Lincoln Lodge, in Lafayette. The forty-five members present heard Dr. Harry C. Buhrmester, of Lafayette, speak on "Military Neuropsychiatry."

Vanderburgh County Medical Society members met at Hotel McCurdy, in Evansville, on March twelfth. The eighty members and guests present heard Dr. Franklin D. Johnston, of Ann Arbor, Michigan, speak on "Coronary Artery Disease."

Wabash County Medical Society members held their regular monthly meeting in the Hotel Indiana, in Wabash, on March thirteenth, with eleven members present. Dr. W. U. Kennedy, of New Castle, spoke on "Socialized Medicine in Europe."

Warrick County Medical Society members heard Dr. Pierce MacKenzie, of Evansville, speak on "Breech Extractions," at their meeting in the Legion Home, in Boonville, on March twelfth, when eleven members were present.

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. F. M. Gastineau, Indianapolis
President-elect—Mrs. S. J. Petronella, East Chicago
Corresponding Secretary—Mrs. C. L. Bock, Indianapolis
Treasurer—Mrs. A. W. Ratcliffe, Evansville
Press and Publicity—Mrs. A. B. Richter, Indianapolis
Secretary—Mrs. Leon L. Blum, Terre Haute

The Woman's Auxiliary to the Indiana State Medical Association wishes to express its deep appreciation to its president, Mrs. Frank Gastineau, for her sincerity and endless effort in making this a successful and interesting year. Our membership has increased, and we have also made gains in many other respects. May our auxiliary continue in its progress.

COUNTY NEWS

Allen County: An important meeting was held at the home of Mrs. Elmer Singer, on March twenty-sixth, at which time Mr. Ray E. Smith, assistant to the executive secretary of the Indiana State Medical Association, spoke on "Mutual Medical Insurance Corporation." He included in his talk a discussion of Indiana's Prepayment Medical Care Plan, sponsored by the Indiana State Medical Association.

On April second, a dinner party was held jointly by the Allen County Medical Society and the Allen County Woman's Auxiliary, at the Fort Wayne Country Club. Card games and songs by the Barber Shop Chorus made up the entertainment.

Delaware-Blackford County: An outstanding tea party was given March nineteenth by members of the Delaware-Blackford County Medical Auxiliary at the home of Mrs. T. R. Hayes. The party was given in honor of wives of interns and resident physicians at the Ball Memorial Hospital. Mrs. Arthur Rettig is president.

Floyd County: Mrs. Frank Gastineau was the guest speaker at the luncheon meeting of the Floyd County Medical Society Auxiliary, held at the New Albany Country Club, on March fourteenth. Her topic was "Socialized Medicine."

Vanderburgh County: Mrs. J. D. McDonald is the new president. On April eleventh a public program on "Cancer Control" was held in the evening at the Central High School Auditorium.

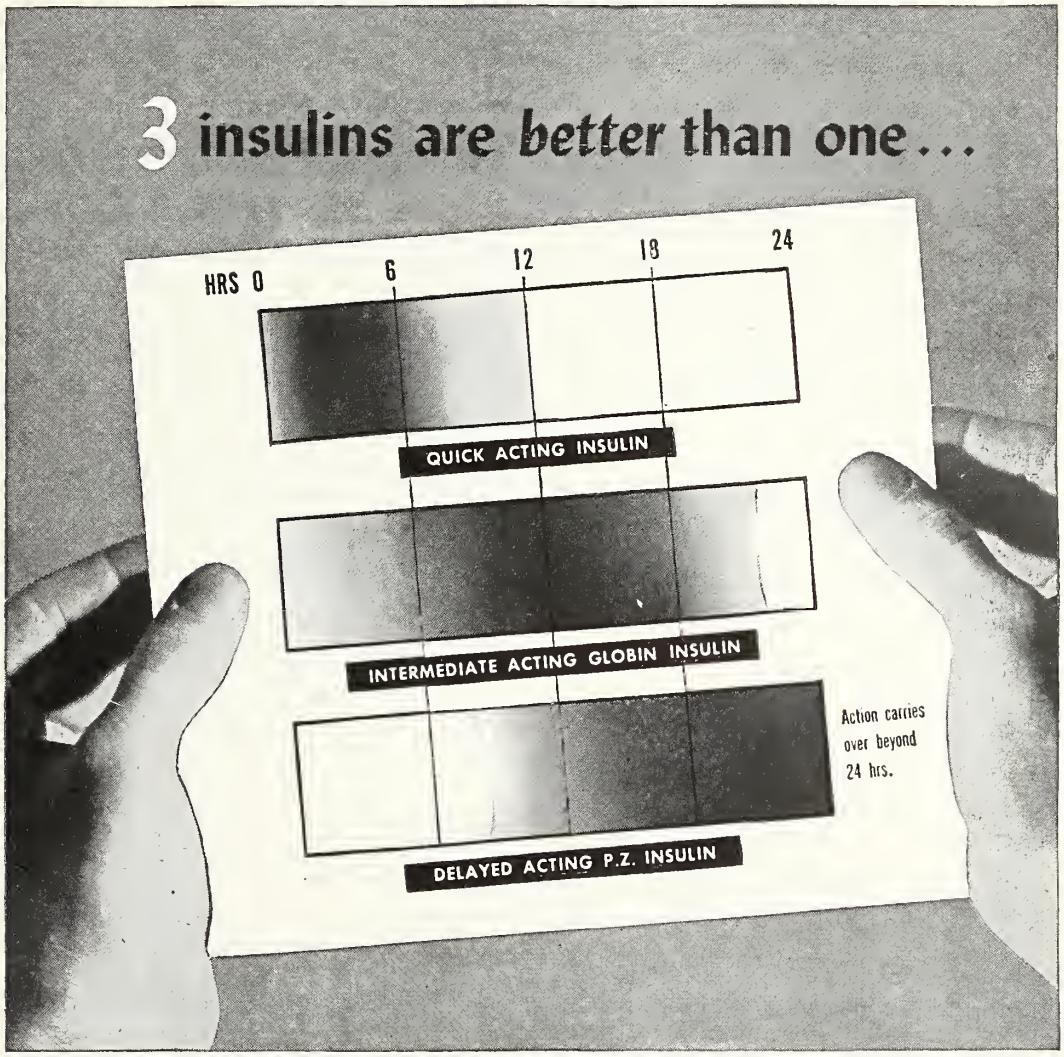
INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—March, 1946

Diseases	*Mar. 1946*	*Feb. 1946*	*Jan. 1946*	*Mar. 1945*	*Mar. 1944*
Chickenpox	529	273	297	529	661
Measles	4371	1150	212	142	1103
Scarlet Fever	517	449	302	782	848
Smallpox	5	2	2	10	3
Paratyphoid Fever	1	.....	.....	.....	2
Typhoid Fever	4	4	1	10	16
Whooping Cough	109	80	83	60	67
Diphtheria	57	71	62	39	33
Influenza	74	200	405	54	52
Pneumonia	35	35	36	23	40
Mumps	191	90	49	456	238
Rheumatic Fever	1	.....	.....	.....	.....
Poliomyelitis	3	1	2	2	1
Undulant Fever	9	3	1	1	5
Cerebrospinal Meningitis	13	14	12	19	37
Encephalitis Lethargic	1	2	1	.....	.....
Septic Sore Throat	42	10	13	6	23
Erysipelas	2	2	2	1	1
Tularemia	2	5	3	.....	.....
Malaria—Acq. Outside U. S.	53	10	19	2	10*
Malaria—Acq. Inside U. S.	1*	.....	.....	.....	.....
Infectious Jaundice	4	1	1	3	3
Dysentery	1	.....	.....	.....	.....
Impetigo	7	8	11	.....	2
Ringworm	12	.....	.....	.....	.....
Septicemia	1	.....	.....	.....	.....
Rubella	30	5	2	9	14
Vincent's Angina	4	1	1	.....	2
Conjunctivitis	1	1	1	2	.....
Tuberculosis, Pulmonary	262	163	196	426	146
Tuberculosis, other forms	12	12	8	7	.....

* Not stated as to whether the disease was acquired outside or inside United States.



THE PHYSICIAN treating diabetes today has the choice of three types of insulin. One is rapid-acting but short-lived. Another is slow-to-start but prolonged. Intermediate between them is the new 'Wellcome' Globin Insulin with Zinc which starts fairly promptly and continues *for sixteen hours or more*. Action is maximal during the times of major carbohydrate intake but diminished toward bedtime so that the likelihood of nocturnal reactions is decreased. Today, the physician is wise to consider all *three* insulins.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Available in vials of 10 cc., *80 units in 1 cc.* and vials of 10 cc., *40 units in 1 cc.* Literature on request.

'Wellcome' Trademark Registered

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 and 11 EAST 41ST STREET, NEW YORK 17

Books

REVIEWED

JOURNAL OF THE HISTORY OF MEDICINE AND ALLIED SCIENCES. (Volume I, No. 1) George Rosen, Editor. 182 pages. Price $7.50 per year (published quarterly). Henry Schuman, New York 21, New York, 1946.

The Journal of the History of Medicine and Allied Sciences is devoted to the publication of work relating to all aspects of the history of medicine, public health, dentistry, nursing, pharmacy, veterinary medicine, and the various sciences that impinge on medicine. This publication is beautifully designed; is printed on a rag content paper; and contains numerous illustrations. Anyone interested in the History of Medicine or Allied Sciences would find it a charming and valuable adjunct to his library.

INDUSTRIAL OPHTHALMOLOGY. By Hedwig S. Kuhn, M.D., Hammond. Cloth-bound. 294 pages; 114 text illustrations, including two color plates. Price $6.50. C. V. Mosby Co., St. Louis, 1944.

Few oculists would have the zeal to search out and study the many monographs extant on the application of ophthalmology to industry and subjects pertaining thereto. The author has accomplished this stupendous undertaking and, by incorporating this material with personal observations and experiences, has produced a comprehensive treatise and reference handbook, the first to be printed on the subject, and to her belongs priority in this field.

In the present war the relation of visual functions to industrial practices has become impressively important. Tests for determining visual skills are described in detail with due regard for conserving the examiners' time. Each factory job has visual requirements, and the workman has to be fitted to the job to attain maximum performance in speed, accuracy, and endurance, and to minimize spoilage of materials, wastage of time, and liability to accident.

The chapter on eye protection deals with machines, tools, and materials; the several types of goggles with their uses and care; standards of lighting, color contrasts and harmony; and medicolegal provisions relating to eye accidents. Dr. Albert C. Snell contributed a chapter of fifty-two pages on industrial accidents caused by solid bodies; it is so comprehensive that it constitutes a monograph. Chapter VI, on radiant energy, presents welding and radiation in its various aspects. The discussion on epidemic keratoconjunctivitis is an extended summary of the subject, and is particularly thorough.

The appendix includes toxic hazards with a glossary of toxic substances and their effects, a check-list for industry, rehabilitation, the blind in industry, and the 1940 A. M. A. appraisal of loss of visual efficiency.

The bibliography comprises one hundred and twenty references and eighteen personal communications. The index of eight double-column pages is a real reference table that enhances the value of the book.

The fluent style of the text, pleasing diction, and clear print make reading easy and rapid. The oculist who uses this book has an intimate introduction to the eye problems of modern industry.

C. W. Rutherford, M.D.

INDIANA STATE BOARD OF HEALTH

MORBIDITY REPORT FOR THE YEAR 1945 BY CITIES BY MONTHS

Diseases	*Jan.*	*Feb.*	*March*	*April*	*May*	*June*	*July*	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*	*Total*
Chickenpox	428	412	476	225	181	134	39	9	8	59	130	249	2350
Measles	20	32	131	85	121	126	27	21	14	12	12	27	628
Scarlet Fever	292	382	448	279	272	149	40	31	47	113	142	117	2312
Smallpox	4	5	5	5	7	1	0	0	0	1	1	2	31
Typhoid Fever	1	0	9	5	2	5	2	1	12	4	3	1	45
Whooping Cough	14	19	37	26	49	49	96	100	58	82	72	63	665
Diphtheria	17	30	33	9	12	17	9	11	29	31	34	34	266
Influenza	17	18	35	3	9	3	2	5	8	8	49	2219	2376
Pneumonia	1	1	9	2	2	1	0	1	0	6	2	1	26
Mumps	196	238	375	229	195	158	35	27	23	22	40	24	1562
Poliomyelitis	1	1	1	0	2	6	1	27	53	18	9	3	122
Epidemic Meningitis	16	7	10	11	11	5	2	4	8	7	10	8	99
Nonepidemic Meningitis	0	0	0	1	0	1	0	1	0	0	1	0	4
Trachoma	1	0	0	0	1	0	0	0	0	0	0	0	2
Rubella	3	0	6	7	8	5	2	2	0	5	0	1	39
Septic Sore Throat	0	1	5	0	0	0	0	8	0	12	10	6	42
Encephalitis Lethargic	1	0	0	0	0	0	0	1	2	2	0	0	6
Noninfectious Encephalitis	0	0	0	0	0	0	0	0	1	0	0	0	1
Tularemia	2	0	0	0	0	0	0	0	0	0	1	0	3
Malaria, Acq. Outside U. S.	0	0	2	1	0	2	3	4	2	5	3	2	24
Malaria, Acq. Inside U. S.	1	0	0	0	0	0	0	0	0	0	0	0	1
Tetanus	0	0	0	1	0	0	0	0	2	1	3	1	8
Dysentery	0	0	0	0	2	0	0	0	6	5	0	1	14
Undulant Fever	5	0	0	1	0	0	0	2	0	0	0	0	8
Rocky Mt. Spotted Fever	0	0	0	0	1	0	0	0	0	0	0	0	1
Vincent's Angina	1	0	0	0	1	0	0	0	0	0	0	0	2
Impetigo	0	0	0	0	0	0	2	1	0	0	2	4	9
Erysipelas	1	0	0	3	1	1	1	1	2	0	2	0	12
Rabies in Man	0	0	0	0	0	0	0	0	1	0	0	0	1
Silicosis	0	0	0	1	0	1	0	0	0	0	0	0	2
Filariasis	0	0	0	0	0	0	1	0	0	0	0	0	1
Conjunctivitis	0	0	0	0	0	1	0	0	0	1	0	3	5
Paratyphoid	0	0	0	0	0	0	0	0	1	0	0	0	1
Ringworm	0	0	0	0	0	0	0	6	3	0	0	0	9

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POSTWAR VENEREAL DISEASE PROBLEMS AND TREATMENT

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Our postwar venereal disease problems are complicated by several old and some new contributory factors. During wartime some of these have accounted previously for increased venereal disease rates during furloughs, leaves, changes of station, or in returnees from overseas duty; others may account for greater increases to come, particularly with those mentioned, and in addition with separatees.

Progressively inclining rates coincident with the anticipated or false peace were marked by sharp upsurges following V-E Day and again V-J Day, and paralleled in civilian and military population alike. In our own State of Indiana, gonorrhea rose from 87 per cent in May to 93 per cent in November, 1945, of all reported cases of venereal disease. Now reported gonorrhea is decreasing, but in the same period the number of new cases of syphilis has risen from 5.6 per cent of the total to 14 per cent in March, 1946.

Certain effective measures accepted and followed as a war necessity are never as gracefully or faithfully enforced in peacetime, and result in diminished co-operation of civilian agencies and individuals, analogous to a relaxation in discipline in the armed forces. An increase in places of rendezvous or places of contact has likewise shifted. So, increased efforts must now be placed on contact tracing, case finding, and case holding.

Greater promiscuity by reason of unrest, by the inability of many returning service men to civilian life and of dislocated defense workers to adjust themselves to their changed status, marital maladjustment of short or hasty war marriages, or readjustment of longer marriages with resultant quarreling and overindulgence in alcoholics too often end in extramarital exposure and possible infection.

Unemployment, uncertain employment conditions and financial pressure or disappointments are vital factors. All of these, unless curbed, will contribute to higher incidence.

The number of new or reinfections is no doubt tangible proof that the widely-publicized rapid treatment methods have developed a disregard of caution, reduced the fear of consequences, minimized an appreciation of the gravity of infection with the venereal diseases, and has resulted in too optimistic views, both lay and professional.

Penicillin has proved itself to be of noteworthy therapeutic value in the venereal diseases, but it also has its limitations. Satisfactory results depend on its proper use in certain time-dosage manner and close post-treatment observation. This antibiotic drug seems adequately effective in the great majority of gonococcus infections, has little if any proved value in chancroid and the granulomas, while its final evaluation in syphilis is still under study, and is yet to be determined. Stokes says, "From A.D. 1943, it will take a year to guess, two years to intimate, four years to indicate, and a decade or more to know what penicillin does in syphilis."

A nation-wide organized study has been in progress under the military committee and the syphilis section of the National Research Council to determine the optimum method to use. Some twenty-six treatment schedules have been used for more than a year and a half, carefully tabulated and analyzed, some discontinued, and some seven are still continued and being further studied. They have been varied from:

1. Sodium penicillin in aqueous solution 2.4 million units (60x40 mg. Q. 3 h.) arsenoxide 320 mg.

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(8x40 mg. Q. d.) Bismuth subsalicylate 600 mg. (3x.02 gm. 1, 4, 8th day).

2. Sodium penicillin aqueous solution 15 days 2.4 million units (120x20 mg. Q. 3 h.).

3. Same as 2—15 days—arsenoxide 480 mg. (8x 60 mg. alternate days) Bismuth subsalicylate 1200 mg. (6x.2 gm. 3rd day).

4. Sodium penicillin aqueous solution 15 days 9.6 million units (120x80 mg. Q. 3 h.).

5. Calcium penicillin in peanut-oil-beeswax, 4.8 million units (8x600 mg. 1 Q. d.) 8 days.

6. Calcium penicillin in peanut-oil-beeswax, 16 days, 9.6 million units (16x600 mg. daily).

7. Calcium penicillin in peanut-oil-beeswax, 8 weeks (16x600 mg. units twice weekly).

Changes in time coverage and total unitage are subject to apparent trends of clinical response or expediency and necessity.

"Commercial penicillin has been a changing mixture of various substances since the inception of this organized study. The content of impurities has gradually decreased as potency in terms of units per mg. has increased. The relative amounts of the several identified penicillin fractions G, F, X, and K have likewise varied from time to time. These two changes and perhaps others suggest that therapeutic efficacy may not have remained constant, and that it may be significantly different today than it was originally. It is not now possible to assess the extent to which these changes may have effected the results reported." (Personal correspondence from Joseph Earl Moore, M.D.)

Time is proving an increasing number of recrudescences of their gonorrheas, or the creation of asymptomic carriers inadequately or badly treated, and the occurrence of clinical infectious relapses of their syphilis from the administration of previously too-low dosages, and perhaps for much of our increased incidence in returnees, separatees, and civilians.

The lack of, or unwillingness, to co-operate in follow-up by patients treated for gonorrhea, but who unknowingly acquired syphilis simultaneously, is too often seen. Some of these develop their syphilis after a prolonged incubation period due to their penicillin treatment, which had masked or retarded a previously-undiagnosed syphilis.

The results of doubtful or positive serologic blood tests for syphilis made routinely at Service Separation Centers are not always explained or told to the service man at discharge. If he has an infectious clinical venereal disease, he is not discharged until after receiving at least the minimum prescribed adequate treatment. Without any clinical signs of his infection he is discharged, but a resumé of any previous acute syphilitic treatment, or none, while in service and his separation blood and spinal fluid tests are later forwarded to the Division of Venereal Disease Control of the Indiana State Board of Health. These are again channeled by us through local health officers or to private physicians in the separatee's home community. The communication of such data, particularly in separatees who have had malaria, to the patients' families will be a source of worry and perhaps difficulty in personal and family relations. The results of such tests unsupported by history, with no objective symptoms and without any previous treatment, must be interpreted with caution.

The possibility of both technical error and false positive reactions must be kept constantly in mind. Such doubtful or false positive results may occur in a number of diseases, such as acute upper respiratory infections, but especially malaria, infectious mononucleosis, infectious hepatitis, and some of the other tropical diseases. With the large number in the armed forces who did have malaria, such false tests usually occur when the disease is reactivated and when the malaria parasites may be demonstrated in the blood. Such tests are found to be only weakly positive when quantitative readings are available, and are usually fluctuating or transitory. Careful, better physical examination is imperative. Treatment should not be instituted in these cases until blood specimens have been rechecked over a sufficiently long enough time to confirm a diagnosis of syphilis. Again, tact and care should be exercised in the communication of the results of these tests to others. If false or biologic in type, they may become negative spontaneously in two to three months. It has been estimated that as high as 17 per cent non-syphilis may have been treated during the War period because of false positive tests and such selective servive routine examination, and now again many more will be in the demobilization period. Premature diagnostic conclusions, unnecessary treatment, and ensuing sociological problems may result. The medical and social responsibility for this type of case is purely civilian, and is a delicate one. Increased sensitivity of tests without high specificity and unless in trained, qualified technicians hands will also greatly augment this.

Current press and magazines advise John Q. Public of the availability of the wonder drug penicillin in any desired shape or form from chewing gum, oral tablets, cosmetics, and tooth paste, to prophylactic jellies. Fortunately, such products must carry content and directions for their use, as well as their indications. They do, however, tend to encourage self-diagnosis, self-treatment, and a greater confidence in lay ability to self-judge results. The physician first ascertains what his patient is conscious of or complains of, attempts to determine the specific cause, and lastly, by professional training and experience the physician alone should evaluate the results of treatment failure or cure.

The efficacy of penicillin therapy is dependent on proper diagnosis, its proper indication, proper care as to refrigeration, proper preparation, its age, and with therapeutic response to it as well as to the physician's knowledge of other possible coexisting pathological conditions, and for which he may use it in combination with or in addition to other drugs.

Inadequate dosage, the delayed incubation and masking of simultaneously-acquired other infection, and the lulling into a sense of false security of symptomless carriers is costly to the individual's health and also to his community. The limitations of penicillin must be better understood in the interest of public health. Pharmaceutical laws aided by state and municipal health departments should be amended or reinterpreted with new regulations promulgated. These would materially curb its indiscriminate use and make it available on the advice and under the direct supervision of or by a physician.

Educational programs should honestly appraise the public of the limitations of the miraculous rapid cures and appeal for prolonged observation and follow-up, and the necessity of competent medical advice.

The incidence of clinical infectious relapse in early syphilis in patients treated with penicillin is at least equal to that of standard treatment, and is certainly greater than that found with any of the intensive arsenic-therapy regimes.

In our own series of early darkfield positive syphilis treated under the National Research Council study, 2,400,000 units of penicillin alone without any adjuvant combination therapy, given at three-hour intervals over fifteen days, was used. Our own results at a recent analysis follow in percentages.

	PRIMARY SERO-NEGATIVE *Per cent*	*PRIMARY SERO-POSITIVE* *Per cent*	*SECONDARY* *Per cent*
Infectious relapse		5.95	11.76
Present-sero-negative	96.5	28.57	29.40
Reinfection	3.44		

Six and six-tenths per cent of our patients were retreated at fourth to fifth month (113-168 days) because of clinico-serological relapse. At last analysis 42.17 per cent were satisfactory or completely negative.

The lessened hazard and greater safety of penicillin therapy and the lack of untoward reaction has been the greatest argument for its use. In our Indianapolis City Hospital series of massive five-day drip therapy (approximately 1,200 cases from February, 1940), our treatment results are:

	Per cent
Primary sero-negative	96.54 satisfactory
Primary sero-positive	83.98 satisfactory
Secondary	78.07 satisfactory

Our infectious relapse rate is under 5 per cent and our mortality rate is .4 per cent for the entire series.

The Committee on Venereal Disease of the Indiana State Medical Association is fully aware of the state of confusion as to the best treatment methods and of the many combinations being used, many of which are inadequate and predicated on unsound lay or commercial viewpoint. The committee has recommended that in penicillin therapy of gonorrhea a minimum of at least 200,000 units in the male, and much higher in the female, should be used. If an aqueous solution is used, it should be spread over as long an uninterrupted period as possible at two and one-half to three-hour intervals in order to maintain an effective blood level concentration. It had previously been suggested that penicillin therapy in syphilis was still in an experimental stage and should be used with reservation and with frequent prolonged observation.

VENEREAL DISEASE EPIDEMIOLOGY IN WARTIME

In a recent issue of the American Journal of Public Health, J. R. Heller, Jr., discussed the joint responsibility of military and civilian health authorities for venereal disease control in wartime. Selective Service System blood tests disclosed syphilis in more than 700,000 men, the majority of whom were placed under, or returned to treatment. A total civilian prevalence of three million cases was estimated on the basis of tests on the first two million selectees.

The necessity for cooperation between military and civilian health authorities is stressed, because the success of venereal disease control programs among military personnel depends upon effective case-finding and case-holding methods among civilians; while the civilian program, in turn, is furthered by efficient case finding and contact reporting by the armed forces. The development of more satisfactory reporting forms by the Army and Navy has improved contact reporting and follow-up by civilian agencies. Tabulations indicate that approximately half the persons located as contacts are found to be infected, and that about one-third of those located are brought to treatment for the first time as the result of the investigation.

One of the greatest problems facing the health officer is the holding of syphilitic patients until rendered noninfectious. Lapsing from treatment became the rule under the old forty-week minimum schedule of twenty injections each of an arsenical and a heavy metal. Newer rapid types of treatment usually involve hospitalization. This is provided by eleven federally-operated and fifty-two state-operated rapid treatment centers, and by an increasing number of general hospitals.

As to the postwar situation, the author points out that service men are not being released with venereal disease in an infectious stage, but are either rendered noninfectious or, in cases requiring further observation, referred to civilian health agencies for follow-up. He stresses the need for more efficient contact reporting and case finding, along with more general blood testing among industrial workers, applicants for insurance, and persons in clinics and hospitals.

—*Am. J. Pub. Health*, New York, **35**:1210-1216, (Nov.) 1945.

REMARKS ON EARLY SYPHILIS

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FORT WAYNE

Today the practicing physician often has syphilis to combat even though a fairly intensive campaign has been pursued over a number of years for its control, if not its eradication. Complete suppression of the disease is perhaps not to be seen within the lifetime of the present-day medical profession, yet it is another goal for us to look forward to, and it is a possibility well within the realm of human effort. The statistics compiled from the figures found during the induction of the first and second million men for military service brought us to the realization that the disease is all too prevalent in this country. Conditions such as were found during the war period were favorable for the treatment of many infected individuals whether or not they desired it. The military surgeon found relatively little trouble in administering intensive treatment to those under his care. The civilian population was behind the war effort to the utmost; so the spirit of aiding the country, which was so current at the time, undoubtedly caused many to seek treatment who would not otherwise have done so. Today a large part of the armed forces are back in civilian life. We are tired of even hearing of war; consequently, the country as a whole is not so intent on pulling together, and a general letdown in a great number of things has come to pass. Along with it has gone the pursuit of stamping out venereal diseases — syphilis in particular. Such being the case, unfortunately, we of the medical profession must not enter into the spirit that prevails in at least some quarters. The side we represent must relentlessly pursue our goal even though it at times seems beyond the horizon. Science is on our side. We must take the implements it has to offer and put them to work in our everyday practice. Thus, will our goal become less dim.

Postwar problems are quite apparent to the physician. New problems have come to each and every one of us through just the fact that our military forces were in Africa, South America, Southern and Central Europe, as well as in the Pacific area, in Australia, India, China, and now in Japan. Even if a shot had never been fired or any man wounded in any of the places mentioned, we still would have had medical problems in this country presented by the veterans of overseas service. One certain thing we have been confronted with is the problem of distinguishing between the infected and non-infected returned service man. Is the doubtful or positive serological report of the blood specimen taken at the time of his separation something or nothing? The answer to the question just asked is, unfortunately, not often solved by the simple procedure of taking a blood specimen and in a few days reading a report from a favorite private or state laboratory. Often the net result of the blood tests drawn so simply and confidently turn out to add fuel to the fires of confusion which are already well-stoked. At the minimum, three months of very careful follow-up must be devoted to each case. Sometimes a year will elapse before the verdict is known, and occasionally no definite decision can ever be rendered. Laboratory work, clinical investigation, and observation carefully scrutinized and weighed pro and con fortunately usually reward the physician with the correct answer, but not without his having used all the resources he can possibly muster.

Another postwar problem tossed gently but very firmly to the medical profession, and one of great importance, is the follow-up of the individual who was freshly infected and subsequently treated while in service. For the last year and a half of combat, the majority of such cases received intensive penicillin therapy. Due to conditions and close supervision in the forces, very often the infection was diagnosed when still in the darkfield positive sero-negative state; thus, with the intensive treatment given at the optimum time, to date we think excellent results were obtained. The individual was rendered non-contagious very promptly, returned to duty with a minimum loss of time, and very often never had a positive blood recorded. Undoubtedly penicillin therapy served its purpose at the time, but in spite of all, the treated individual must be observed over a considerable period of time by clinical examinations and laboratory procedures. These are the minimal requisites in the struggle to eradicate syphilis in this country. Such observations will also help to evaluate the efficiency of "the wonder drug" so recently bestowed upon us. Penicillin is still penicillin, more refined salts and methods of administration without doubt will come into being; maybe it will displace arsenotherapy entirely—who knows? Now we do know that repeated evaluation of the patient already treated with it is necessary before a cure can be pronounced. Let not one of us be guilty of not carrying out the extended period of observation now deemed imperative once we have assumed the care of a case of early syphilis where the antibiotic substance is thought to be the most effective. The medical profession is still searching for just the right niche for this drug. Do not just give shots for one week and then dismiss the case. Inform the person of the follow-up period necessary before treatment is started.

Another aid in the ultimate control of syphilis is the operation of an adequate follow-up system of contacts. Today, at least, some effort is made in all clinics and all states to carry out this procedure, but its efficiency rating certainly is low. Investigation of contacts can be carried out with-

out embarrassment of the individuals involved if the person doing it will use ordinary courtesy and explain the reason for the investigation—a contagious disease. No doubt in the train of events some malicious individuals will be found, but in the vast majority of cases the person's sense of fair play to his or her acquaintances can be appealed to, and good results obtained. Actual police interference is very seldom required.

The darkfield examination of any suspected lesion on the body, but particularly on the genitalia, is another means of lowering the spread and incidence of syphilis. It is a reliable laboratory procedure as yet too infrequently used. The diagnosis of syphilis in the very early stage is made under the laboratory microscope, and *not* by clinical impression. By the use of this examination the early infections can be ascertained and controlled quite often before the blood becomes positive, thus the optimum period of treatment can be used to its best advantage. There is *no* local treatment for a genital lesion until this laboratory test has repeatedly proved negative over a seven-day investigation. The daily blood examination should accompany it. If the darkfields prove negative, then the minimal three-month serological follow-up, with inspections of the skin and mucous membranes, is in order. A blood specimen should be drawn each week at least for the first month, and then not less often than at two-week intervals until ninety days have passed. No antisyphilitic drugs should be given during this period of investigation. Only at the end of three months can the whole story be told. Puncture of the enlarged lymph glands with the examination of the washings under the darkfield microscope and the use of the flocculation or Wassermann tests done on the serum gathered from the local lesion are also methods of early diagnosis to be kept in mind in investigating a suspected case. If they prove negative, then the three-month serological follow-up is in order. Repetition of the blood test is absolutely indicated in each and every case of gonorrhea and chancroid which comes to the practitioner for care, no matter which therapeutic course is followed. Many surprises will greet the one who carries out the follow-up of such cases.

The use of accepted drugs in the treatment of syphilis is another means recommended for the effective control and cure of the disease. Only in very exceptional cases is the use of a non-council-accepted preparation warranted. Even a superficial inspection of the literature accompanying a remedy soon permits one to know if it is a recognized preparation. Certainly there is no dearth of standard drugs. It is the physician's responsibility to know he is using the best chemicals available in combatting this widespread disease instead of trusting to luck with some compound which was called to his attention by a super-salesman or merely by a card in the mail. The road to a successful attack on the infection is difficult enough without taking any chances with an unknown preparation. To date the processing of penicillin is under strict control; hence, we have no worry from that side, but we do have a great one when considering the arsenical, mercurial, bismuth, or iodide preparation to be used. Any drugs with merit have received the approval of the Council on Therapeutics as safe and effective in treating syphilis. Just which brand of the accepted drug one chooses is unimportant so long as it is the proper one for the stage of the disease you are called upon to treat. Trivalent arsenical drugs, such as neoarsphenamine, arsphenamine, mapharsen, dichlorphenarsine hydrochloride, phenarsine hydrochloride, and chlorarsen are the ones which should be used in the treatment of early syphilis, not pentavalent preparations such as tryparsamide or aldarsone. The latter have no spirocheticidal properties, so are advisable only in late syphilis in which the nervous system is involved. Perchance the chosen drug is not tolerated favorably by the individual under treatment, usually a shift to a similar one of a different manufacturer is all that is necessary. Hope of using the powerful arsenicals should not be given up just because one particular form is not tolerated. One should, however, be constantly on the alert for untoward reactions even after the same drug has been used for some time in the case at hand. Happily, bismuth causes very few reactions, and those that do occur give ample warning of their approach; so if the drug is withdrawn at that time, a serious complication is averted. The same is true for the now infrequently-used mercurials. Oral administration of the iodides for a few days before their intravenous use is usually sufficient for the detection of an idiosyncracy which precludes their use. Today we have council-accepted drugs which contain a combination of arsenic and bismuth for use in persons who present inaccessible veins. Ample treatment can thus be given intramuscularly to individuals who for some reason or other cannot be treated intravenously.

The seemingly insignificant point of the physician's having sharp needles is a very poignant one. Not only is the vena puncture or intromuscular injection made more readily by the physician; it is much less painful to the patient, thus better co-operation is obtained. One certain method of further discouraging an often already-discouraged patient is consistently, or even semi-consistently, to "get a little medicine out in the tissue," or give the injection of some of the newer arsenicals too slowly so a vena spasm results. The development of a tolerance by the gluteal muscles for the injection of medications is fortunate; nevertheless, it does not permit a careless technique. There still remains the proper area and mode for the introduction of medication into the buttocks. A smooth course of treatment encourages the patient to continue therapy, thus less infectious relapses take place.

Penicillin therapy for early syphilis is at present necessarily done in the hospital. Adequate care and observation cannot be given when the patient treats himself. Self-injection of insulin once or

twice a day is vastly different from the self-administration of penicillin eight to twelve times a day for a minimum of sixty injections. Again, such a fashion of therapy gives the infected person a false sense of security. Anything he can treat while afoot and by himself certainly cannot, in his estimation, be serious; hence, the follow-up scheme recommended is not apt to be sustained. Oral penicillin should not, for the present, even be considered in the treatment of syphilis. Sometime perhaps a suitable compound will be worked out, but at the present it should not be used. No reports or suggestions for the use of penicillin in oil or wax in syphilis treatment are available. Until some are released by the Penicillin Panel Group, the use of the form mentioned should be foregone Many systems of treatment are available to the practitioner if only he will consult one of the standard textbooks on syphilis. One publication is so up-to-date that a chapter on penicillin therapy in syphilis is included. No special system of therapy for the arsenical, bismuth, iodide regime, or penicillin routine will be recommended in this general dissertation. Many articles pertaining to the first-mentioned have been published over a period of years, and the current medical publications are sure to contain any new suggestions for the use of penicillin in syphilis therapy. The familiar chemotherapy still has a very definite place in our armamentarium. The main factors to be remembered are that early syphilis can in general be treated on a system without so much regard for the individual, whereas the therapy for late syphilis (any case of more than four years' duration) has to be individualized according to the physical and laboratory findings.

In spite of the Indiana law demanding the prenatal blood test, too many syphilitic babies are born. An occasional such child cannot be averted due to a late infection or the non-arrival of the pregnant woman in a physician's office or public clinic. In any event the blood test of the prospective mother should be taken at the time of her first visit and not delayed until the time of delivery, or any other time previous to it. The earlier a specimen is drawn, tested, and reported, the less chance of an infected child in this world. Infection of the fetus does not take place until between the fourth and fifth months. An infection discovered before or at that time can be effectively combatted and a healthy baby born. By means of the blood test the disease in the mother can be discovered and treated, thus preventing the infection in the child in almost 100 per cent of the cases. A very creditable job for any physician! Any child born of a mother now negative, but who at one time was positive, should be followed with quantitative blood tests for a three-month period after birth to determine its exact status. This applies even though older siblings born after the maternal blood reverted to normal have proved to be negative. The practice of taking the maternal blood test early in pregnancy is good preventive medicine. A twofold result is often obtained. An infected person is treated, and the infection is prevented in another.

The only comment to be made in regard to late syphilis in this paper is again to suggest a renewed effort to prevent it by the diagnosis of early syphilis, and, when diagnosed, by proper treatment and observation over the years. Observation includes making a spinal or cisternal puncture in an early case at the appropriate time and physical examinations at definite intervals; thus many, if not most, of the late complications can be prevented. A cure is, of course, less apt to be obtained in late syphilis (over four years' duration) than in the early cases. Control of the disease is, however, very often attained, and the person lives out a span of life commensurate with his or her general physical condition. Late syphilis with its complications, particularly those of the nervous system, is indeed a sad sight to view. Early diagnosis and adequate treatment are certain to be found lacking in most such cases.

Unquestionably, infections of syphilis run a benign or relatively benign course in some individuals. The life span and activity are apparently not affected in those persons. Just how many cases come to a spontaneous cure is, of course, not, and never will, be known. Of these facts we are quite well aware, but no physician, no matter how astute he is, can pick the early case which is going to follow along and become a harmless one in so far as the infected individual is concerned. Each early infection of syphilis must be considered a virulent one and treated accordingly. With this idea in mind in handling the case, we can look forward to less and less of the late complications in the years to come, as well as a great lessening of the incidence of the early cases, for contagiousness will be decreased or entirely eliminated.

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ABSTRACT: FATIGUE DUE TO SUGAR DEFICIENCY IN BLOOD RELIEVED BY SPECIAL DIET

Fatigue and dizziness from hypoglycemia, which is a deficiency of sugar in the blood, is effectively alleviated by dietary treatment with high proteins and complex carbohydrates.

Writing in the March 2 issue of *The Journal of the American Medical Association*, Major Samuel C. Karlan and Captain Clarence Cohn, of the Medical Corps, Army of the United States, say:

"Of one hundred cases of fatigue and weakness studied, nine were believed to be primarily caused by hypoglycemia. The main complaints in all these cases were fatigue and dizziness. Unlike the fatigue in ordinary neurasthenia, the fatigue suffered by these patients was not continuous, but occurred at specified times, such as on arising in the morning or several hours after meals. It almost invariably occurred after having missed a meal.

"The treatment used in these cases was entirely dietary. Diets high in proteins and carbohydrates of the more complex variety (starches rather than sugar) with frequent feedings prevented the symptoms in our cases."

THE CLINIC IN VENEREAL DISEASE CONTROL

MINOR MILLER, M.D.

EVANSVILLE

The advent of the newer methods of treatment of venereal disease have not changed the fact that we still have a control problem. They are still caused by the same organisms, and the epidemiology remains the same. They are still spread through promiscuous intercourse, and retain all of their virulence and destructive pathologic potentialities. The profession and the public have been flooded by an enthusiastic press until many believe that the remedy is so simple to administer, and perfect results therefrom so certain, that the patient need no longer consider the contraction of gonorrhea or syphilis as anything more than a mildly inconvenient episode in the more abundant love life of the species. Too many cases are failing to make miraculous response to justify such optimism. When Rockne told a famous Notre Dame team that a Rose Bowl opponent believed that they could win, James Crowley is supposed to have queried, "Haven't they read our press notices, Coach?" There is an adage to the effect that "A barking dog never bites." However, if one desires to avoid unwanted air conditioning of the attire, and lacerations of the cutaneous integument, it is often well not to crowd the canine, lest he refrain from vocalizing and starts to nibble. The spirochete and the gonococcus have not yet been reduced to empty threats. They still retain capabilities for positive and direct action, and the primrose path is still cluttered with unsightly and unhappy recipients of the embrace of Dame Fortune's eldest daughter, Miss Fortune.

None of the new discoveries or treatments have changed the problem of preventing infection. Neither has there been any new finding that has given us any means of immunization, nor are we better equipped in the field of prophylaxis. We still must place our reliance on the early discovery of cases and eliminate the sources singly by eradicating each and every one. The sum total of infections is in direct proportion to the number of contracts of those promiscuous persons carrying and transmitting infection. Reduction of exposure is the only means of prevention which has universally given better morbidity rates. Every untreated (or unsuccessfully treated) case remains as a menace to those with whom there is intimate contact. The more promiscuous these contacts are, the higher the morbidity rate.

Since there is in some quarters a firmly-established belief that venereal disease is easily and quickly cured, precautionary measures have become less observed, and more chances are taken. Inhibitions have been relaxed, and it is not considered necessary to exercise so much vigilance in avoiding infection because cure is believed to be sure and speedy, with not too much inconvenience. Fear of disease or the consequence of disease no longer deter some individuals. Promiscuity no longer has this check. Hence, it becomes more necessary than ever that we seek out, find, and treat all sources of infection. Epidemiology in venereal disease has always been a tough problem. It will probably remain an arduous one. Individuals are prone to conceal the secrets of their sexual contacts, and to resent the disclosure of them by their partners. The official powers of the health officer are often necessarily invoked before some sources can be induced to submit to an examination, or be persuaded to take treatment. On the other hand, there are many persons whose economic situation is such as to prevent them from undertaking prompt and efficient therapeutic measures. Control of venereal disease falls into the province of the health department by virtue of being a public health problem.

There are several *musts* for the health department in meeting the venereal disease control problem. It must furnish the epidemiological service required to ferret out cases, and the follow-up necessary to insure that these cases are rendered non-infectious, and that they are no longer a potential menace to the community. The health department must also provide treatment for those cases unable to provide themselves with adequate therapy. It also must provide for the quarantine of recalcitrant individuals. In the larger centers of population the venereal disease clinic affords the best means of accomplishing this work.

The venereal disease clinic should be more than simply a place where patients may present themselves for free treatment or treatment at reduced rates. While this is important, and never to be omitted in a program of venereal disease control, yet this work, no matter how conscientiously and efficiently performed, will not be effective when used alone. Follow-up of cases to determine that they have become non-infectious is the most important function of the health officer. This activity is not to be confined to the patients served by the clinic, but must be extended to those served by private practitioners of the community.

It is not meant that there should be any interference with the patient receiving private treatment, or dictation in matters of treatment to the physician serving such patients. However, both the health officer and the physician have certain legal and moral obligations to discharge. Venereal diseases are reportable. The physician treating the case therefore has this obligation. The health officer is held responsible for the control measures to be applied, and should take steps necessary to prevent their dissemination. Obviously, since each case remains a problem until sufficient treatment has been administered to render the patient non-

infectious, it is necessary for some system to be evolved to inform the health officer that the patient is presenting himself regularly for treatment. This may be done with a minimum of inconvenience to all, by utilizing a card system which gives such information and can be sent by mail. Failure to receive such reports will automatically call the attention of the clinic investigator to derelictions, and investigations may be promptly made.

It is occasionally necessary to invoke quarantine in some cases in which the patient is uncooperative and refuses to conform to such rules as are conducive to the interests of public health. This is a function of the health department and is an added responsibility of the clinic director.

There are many and varied agencies with whom the clinic should establish cooperative relationships. The courts have many cases in which venereal disease is a factor, and many cases can be uncovered through a good working connection. The same is true of the Police Department and the Sheriff's Office. Examination of prisoners confined to the jails is a very prolific source for discovering cases of venereal disease in persons who are neither concerned about the importance of caring for their own health, nor safeguarding the health of those with whom they come in contact. Probation officers uncover many cases in the course of their investigations, as do many of the welfare organizations. In fact, one might call the roll of the welfare and correctional organizations of any community, and then add to this list the doctors, nurses, schools, labor organizations, employers, fraternal bodies, and yet not complete the list. Suffice it to say that venereal disease must be combatted wherever found, and the help of any and all organizations and individuals must be solicited.

The newer methods of treatment have materially shortened the time necessary to cure many cases of gonorrhea. There is reason to hope that penicillin is effective in certain early syphilitic infections. However, no scheme of treatment has yet been evolved which will positively be 100 per cent effective. Follow-up checks for cure is most important, because those not attaining cure are the most dangerous reservoirs of infection. The speed with which symptomatology disappears lulls many into a state of false security which is by no means justified. This false security, combined with a relaxation of inhibitions resulting from a decreased fear of infection, has, if anything, made efforts directed toward control more imperative than ever. Morbidity rates have not declined, probably have increased, since the advent of these methods of treatment. Many factors are involved and must be considered in determining the reasons for such rates, such as separations during the war period, displacement of population, and a lowering of the sexual moral code consequent thereto.

Methods and mechanics of control have not changed. Venereal infection still remains one of the top public health problems. It still calls for close cooperation of patient, physician, and health department. This cooperation has never been an efficient operation, due mostly to distrust of motives. Until some system of immunization is discovered, it still remains our best approach, and should be strengthened—not abandoned. The health department still has a job to do, and the clinic still has work in the more populous communities. It can provide treatment for those economically unable to finance their own therapy. It can also provide the follow-up investigations of careless or recalcitrant patients for clinic and private patients alike, without interfering with private management of cases. It can locate contact, and cause them to be examined and treated when infected.

There is nothing new in this article. The only excuse for it is that we still have a venereal disease problem and that the role of the venereal disease clinic remains the same. We have had some change in our therapeutic approach, but none in our methods for control.

THE VENEREAL DISEASE CLINIC



Drawing specimen by blood test.



Table in a local clinic.

NEWER METHODS OF TREATMENT OF GONORRHEA

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The superiority of the results of penicillin therapy, to any other treatment now available to the general profession, makes its use the modern treatment of gonorrhea. While various methods of administration of penicillin have been found possible, and to achieve therapeutic results, penicillin powder dissolved in physiological saline solution and given by intramuscular injections seems to be the most effective and most certain of results.

The optimal total dosage is still to be determined, but 160,000 Oxford units has been found to produce a high percentage of first-course cures, with the lowest percentage of treatment failures in several large series of cases studied with adequate laboratory checks of cures and patients under controlled conditions to rule out reinfections. Assays of the unit potency of penicillin powder, as the material reaches the physician, indicate that the potency may be below that at which it was originally packaged and labeled; therefore, use of the 200,000 units prepared vial, commonly available, will insure administration of the apparently optimal total dosage of 160,000 units. Recent blood concentration level studies of penicillin in physiological saline solution, administered by intramuscular injection, indicate that a three-hour interval between injections may be too long to maintain a constant therapeutic level. A two to two-and-one-half-hour interval between injections will maintain a more nearly constant therapeutic level.

The course of treatment which seems best is therefore 200,000 units of commercially-available penicillin dissolved in five and one-half cc. of physiological saline solution with injections of one cc. of the solution drawn into the barrel of a syringe with needle attached and administered intramuscularly into the gluteal muscle at two-and-one-half-hour intervals.

It was formerly believed that female patients were more difficult to treat for gonorrhea than men. With penicillin therapy, comparable results are obtained in both sexes. Investigation of cures of gonorrhea treated with penicillin have confirmed a fact previously suspected with other types of treatment, namely, gonorrhea is more readily cured in the colored patient than in the white patient.

Complications of simple anterior gonorrheal urethritis are cured by the same course of therapy, except in the case of gonorrheal arthritis. In gonorrheal arthritis adjunct injections of 20,000 units should be given into the infected joint cavity directly, one injection on each of two days. Epididymitis, while rare in gonorrhea under penicillin treatment, should receive the usual care, and its eradication should not be dependent on penicillin therapy alone.

Repetition of the above-outlined course of treatment, as soon as a definite diagnosis of recurrence is made, will result in almost 100 per cent final cures. It is my recommendation that sulfathiazole given in conjunction with penicillin therapy, with an initial dose of two grams,followed by the administration of a one-gram dose, four times a day, after meals and at bed time, will enhance the percentage of cures in retreated cases.

Cases are reported where as little as 25,000 units of penicillin in one injection has proved curative. Other cases which have received 200,000 units in divided doses of 20,000 units each, every three hours, have not been cured. Some infections have resisted treatment with as high as 500,000 units in one course, given in divided doses of various strengths and over various intervals. One fact is certain, no course of treatment with penicillin has yet been devised which has proved a cure for every case of gonorrhea.

A course of treatment with penicillin which has been widely recommended is 200,000 units given in divided dosages of 20,000 units each, every three hours. While this course is highly successful so far as percentage of cures is concerned, it has the disadvantage both to the doctor and to the patient of requiring arrangements for treatment both day and night until the course is finished.

Another plan of treatment widely used by the military is to administer 200,000 units of penicillin in divided dosages of 40,000 units each, every three hours, for five doses. Thus, a full course of treatment could be accomplished within a period of twelve hours, and the problem of arranging night treatments dispensed with. This has been even further modified by giving 50,000 units every three hours for four doses, thus completing the course in nine hours. I do not mean to imply that a 200,000 unit course of treatment is necessarily the exact or the optimum amount of the drug to be administered in one course, but it seems obvious from the reports of many workers that a greater percentage of cures will be secured by using 200,000 units than by employing a lesser amount; while on the other hand, a larger amount may prove beneficial in retreating the occasional difficult case, such larger amounts are not usually necessary and their routine use constitutes a waste of the drug, which is still relatively scarce.

Treatment must not be unduly cut short. Individual injections of more than 50,000 units are probably a waste of the drug, although the United States Marine Hospital, at San Francisco, reports giving an initial injection of 80,000 units, followed by three injections of 40,000 units each at three-hour intervals with 235 cures (87 per cent) and 34 failures (13 per cent) from among 269 hospitalized patients thus treated. In a group similarly

treated at the San Francisco City Hospital Clinic they report 182 (84 per cent) cures and 34 (16 per cent) failures. Dr. Koch[1] concludes from these studies that hospitalization of gonorrheal patients is of no advantage. However, it is my belief that patients do better if instructed to avoid heavy lifting or straining, rest as much as possible, force fluids, void frequently, and avoid alcohol for at least a week after initiating the treatment.

The voided urine of the patient under treatment will usually be free of a pus cloud after the third or fourth injection; however, long mucous shreads and comma shreads may persist in the first glass for several days, even in cured cases. Failure of the base urine to be clear of a pus cloud by the end of a course of injections is usually indicative of a treatment failure.

Numerous time studies upon re-occurrence of symptoms following a treatment failure indicate that from 25 to 30 per cent of these reactivations will occur more than a week after treatment. It is therefore necessary that patients be kept under observation for more than a week following treatment, and that they be warned against the dangers of spreading the infection for at least a month. Because of the fact that penicillin will markedly allay the symptoms or entirely cause them to temporarily disappear, even in treatment failures, and because there is no certain provocative test, it is more important than ever that checks of cure be made by studying direct smears and by culture both of urethral scrapings and of fluid massaged from the prostate.

The average general practitioner and even many urological offices do not maintain adequate laboratory facilities, nor do they have them readily at hand, and since the gonococcus may be killed by air-drying in approximately twenty minutes, the feasibility of utilizing cultures to check cures, which is the ideal method of checking cures, often will not be resorted to by a great many of the physicians treating gonorrhea. Therefore, provocation tests must be resorted to, such as massage of the prostate and passage of a 24F sound one week after treatment. A direct smear of the prostatic fluid and urethral scrapings with a platinum loop is made at this time. The patient is instructed to return in three days or sooner if any discharge or gleet is noted. On the three-day check any urethral discharge is smeared on a slide and stained, specimen carefully studied; and if this is negative, the urinary sediment of the first glass is stained and studied. Even on negative findings the patient is warned against possible reoccurrence and urged to avoid sexual intercourse for at least one month, and to return to the office for a final check-up at the end of the month, or immediately if any suggestive symptoms appear.

[1] Koch, Richard A.; Haines, John S.; and Hollingsworth, William Y.: Evaluation of Penicillin in Gonorrhea. Treatment and Control. *J.A.M.A.*, Vol. **129**, No. 7, p. 491, (Oct.) 1945.

Penicillin in beeswax-peanut oil has been used in attempting to reduce the number of injections necessary to treat gonorrhea. This form of therapy has the following drawbacks at present; the optimal formula of the beeswax-peanut oil vehicle has not yet been determined; moderate soreness develops at the site of injection and persists for nine to ten days, and assays of blood serum levels and urine concentrations indicate a widely-variable rate of absorption of from four to over twenty-four hours with intervals when levels are below probable therapeutic concentrations. From early studies it was thought that only calcium penicillin was effective when administered in a beeswax-peanut oil mixture. Later studies show that either the calcium or the sodium salts are effective if a sufficiently highly-refined peanut oil, with water content reduced to a minimum, is used. Vehicle preparations containing four to six per cent beeswax are preferable as they are less viscid and contain smaller amounts of foreign material.

When attempting to use this method of treatment, 300,000 units of penicillin powder in 1.15 cc. of beeswax-peanut oil should be injected subcutaneously over the site of the deltoid tendon. A second similar injection in the other arm should be given in eight to twelve hours. Blood level and urine concentration studies indicate that more uniform and prolonged absorption is obtained by subcutaneous than by deep intramuscular injections. A generalized urticaria has been reported in some cases following use of penicillin, beeswax-peanut oil injections. It is not known yet whether these reactions represent a sensitivity to beeswax-peanut oil, or penicillin.[2]

Penicillin in beeswax-peanut oil has been found to remain stable either in the refrigerator or at room temperature for as long as sixty-two days.[3] Penicillin dissolved in physiological saline solution or in powder form is recommended to be kept refrigerated, and the solution prepared fresh daily. Local penicillin therapy by intra-urethral instillations is valueless.

Oral penicillin therapy may be effective in treating gonorrhea, but it is much less dependable than either injections of penicillin dissolved in physiological saline solution or penicillin beeswax-peanut oil mixtures. Penicillin administered orally is unpredictable of blood serum levels or urine concentrations, apparently because of three factors which must be overcome to achieve therapeutic results; namely, preventing destruction of the penicillin by the acids of the gastric juice, combating penicillinase-producing organisms in the bowel and speeding the rate of absorption from the

[2] Kirby, Captain William M. M.; Leifer, Major William; Martin, Captain Samuel P., M.C., A.U.S.; Rammelkamp, Charles H.; Kinsman, Lieutenant Colonel J. Murray, M.C., A.U.S.: Intramuscular and Subcutaneous Administration of Penicillin in Beeswax-Peanut Oil. *J.A.M.A.* p. 940, Vol. **129**, No. 14, (December) 1945.

[3] Romansky, M. J., and Rittman, G. E.: Penicillin, Prolonged Action in Beeswax-Peanut Oil Mixture. *Bull. U.S. Army Med. Dept.* No. 81, p. 43, (October) 1944.

bowel.[4] Oral penicillin does not appear to be any more effective than sulfathiazole therapy and therefore does not justify the additional expense. To be reasonably effective oral administration of penicillin requires about five times the parenteral dosage.

Gonococci (in vitro), whose tolerance to penicillin had been greatly increased, were found to be readily susceptible to streptomycin; therefore, it may be that when streptomycin becomes generally available that 100 per cent of the cures by chemotherapy may in a short space of time be achieved.[5]

SUMMARY

1. Penicillin in physiological saline solution given by intramuscular injections is the most satisfactory present-day treatment of gonorrhea.

2. The time factor is important. Injections should be given over an eight- to ten-hour period at intervals of two to two and one-half hours.

3. There is little cumulation effect of penicillin; therefore, divide your total dosage into equal parts and the effect of each individual dose is more prolonged.

4. Penicillin dispersed in beeswax-peanut oil may be effective in treating gonorrhea, but rate and interval of absorption will be variable, thereby affecting treatment results.

5. If penicillin beeswax-peanut oil injections are used, 300,000 units of penicillin in one cc. of the vehicle should be injected in each of two injections, subcutaneously, over the deltoid tendon, at an interval of eight to twelve hours according to limited studies.

6. The convenience of fewer injections is achieved only at the sacrifice of large amounts of penicillin.

7. Oral penicillin therapy is much less effective than injection therapy; requires from three to six times more of the drug, and is little, if any, more effective than sulfathiazole.

8. Twenty-five to thirty per cent of relapses occur more than one week after treatment; therefore, treatment checks must be continued for more than a week and should be made by cultures if at all possible.

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[4] Cuiting, Windsor C.; Helpern, Richard M.; Sultan, Ernest H.; Armstrong, Charles D.; and Collins, Charles Leslie: Penicillin By Mouth For Gonorrhea. *J.A.M.A.* p. 425, Vol. **129**, No. 6, (October) 1945.

[5] Miller, C. Phillip, and Bohnhoff, Marjorie, B.S.: Streptomycin Resistant Cocci. *J.A.M.A.* p. 485, Vol. **130**, No. 8 (Feb.) 1946.

PENICILLIN THERAPY IN GENITO-URINARY TRACT INFECTIONS*

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Penicillin is definitely indicated in the following infections: Streptococcus haemolyticus, Streptococcus viridans, Staphylococcus, Gonococcus and Treponema pallidum, but is ineffective in the entire genus hemophilus, Tubercle bacillus, Typhoid bacillus, Salmonella, Shigella, Pseudomonas, Proteus and Colon bacillus infections.[1]

Laboratory methods of diagnosis, especially cultures of urine and stained smears of pus and urine sediment, are most helpful, but are too often neglected in the enthusiastic institution of penicillin therapy. Accurate diagnostic procedures should always precede penicillin therapy. The author has recently seen four pulmonary complications following renal surgery. The first three cases proved to be postoperative pneumonias, were diagnosed by x-ray, and were treated successfully with penicillin. The fourth case proved by x-ray diagnosis to be atelectasis and was treated successfully by bronchoscopic evacuation.

Infections of the kidney will respond to penicillin therapy only under certain conditions. The infecting organism must be sensitive to penicillin. Structural damage to the kidney must not have progressed to a state necessitating surgical treatment. In 1941 a case of staphylococcal pyelonephritis in an infant was cured and reported in *Lancet*[2] by Abraham and associates.

Treatment of upper urinary-tract infections with penicillin has been disappointing when complicated by Escherichia coli,[3] Aerobacter aerogenes, Pseudomonas aeruginosa, and the Tubercle bacillus. These infections are apparently more responsive to treatment with streptomycin.

Treatment of lower urinary- and genital-tract infections has been revolutionized by penicillin.

Gonoccocal infections and common complications of the disease are rapidly cured by the intramuscular injection of 20,000 units of penicillin in normal salt every three hours for twenty-four hours. There are a few failures, and many of these

* Presented before the Indianapolis Medical Society, March 26, 1946, at Indianapolis, Indiana.

[1] Penicillin, *U.S. Nav. M. Bull.*, **44**:453-479, (Mar.) 1945.

[2] Abraham, E.P.; Chain, E.; Fletcher, C.M.; Gardner, A.D.; Heatley, N.G.; Jennings, M.A.; and Florey, H.W.: Further Observations on Penicillin, *Lancet* **2**:177-188 (Aug. 16) 1941.

[3] Helmholz, Henry F., and Sung, Chieh: Bactericidal Action of Penicillin on Bacteria Commonly Present in Infections of Urinary Tract. *Am. J. Dis. Child.*, **68**:236-242 (Oct.) 1944.

failures are due to inaccessible infection in congential and acquired anomalies of the genito-urinary tract. The unsatisfactory results should be carefully examined by endoscopy, preferably with the McCarthy panendoscope. In one penicillin failure we found a double external urethral meatus. One opening led to a blind pouch less than two cm. in length. The penicillin series was repeated and the patient was instructed to inject a solution of penicillin, with a medicine dropper, into this canal every three hours. A cure resulted. Blind epithelialized pouches draining into the urethra are not rare and sometimes require surgical meatotomy by electrocoagulation.

Dilatation of strictures and the evacution of pus-logged seminal vesicles and prostate glands is still necessary. These procedures are performed more safely if the infection is inhibited by penicillin.

Many, and there are many, failures following repeated penicillin therapy are simply reinfections. It is ridiculous to treat a married man for a chronic penicillin-sensitive genital infection unless his mate is also treated. This bacteriostatic agent is not a vaccine. Other failures are the result of the improper use of penicillin. One patient stated that he was treated with two injections four hours apart one day, and that he received two similar injections the next day. Another failure said that he was given "pills of penicillin." Oral[4] penicillin can be used, but requires intelligent co-operation by physician and patient. It must be given in protecting capsules and in large doses.

Penicillin[5] in beeswax-peanut oil, in 300,000 unit dosage, has been made practical by Romansky, Monroe, and others. The single dose is supplied in an ingenious syringe with needle, which is discarded after intramuscular injection. This product has been injected repeatedly once daily for a week or more into individuals without demonstrable ill effects. However, one must avoid the intravenous injection of oil. This is best prevented by the usual technic of inserting the needle into the upper, outer quadrant of the buttock and creating gentle suction with the syringe, to be sure that the needle is not in a vein, before injecting the oil.

Penicillin therapy may be used as a prophylactic as well as a curative agent in genito-urinary surgery. Various types of cellulitis, infected wounds, bacteremia, pneumonia, abscess, peritonitis, epididymitis, erysipelas, osteomyelitis, and arthritis have been treated successfully with penicillin.

Syphilis in all stages has been treated with penicillin and has shown improvement, according to Stokes, Moore[6] and others, but the treatment is not yet standardized. At this time 40,000 units every three hours around the clock for sixty doses is a common method of treatment, and repeated courses are advocated by some.

Chancroid[7] lymphogranuloma venereum and granuloma inguinale are not treated with penicillin.

Toxic manifestations in the form of local or generalized urticaria may be expected in about one per cent of the treated cases. If treatment of the urticaria is necessary, small doses of adrenalin are effective.

Emotional anxiety states, accompanied with mild fever during penicillin therapy, suggest coexistent syphilis. The patient's serology should be checked for at least three months.

Herxheimer reactions manifested by high fever, 104-5 degrees F., may occur early in the treatment of syphilis when large-dosage treatment (i.e., 40,000 units) is instituted. Such reactions should be anticipated and avoided by initiating the treatment of latent syphilis with moderate dosage (i.e., 20,000 units).

Although the exact mode of activity of penicillin is unknown, clinical results have definitely established the value of this substance as a biotherapeutic agent.

[4] Finland, Maxwell, et al: Oral penicillin. *J.A.M.A.*, **129**:315-332, (Sept. 29) 1945.

[5] Romansky, Monroe, J., et al.: Single Injection Treatment of Gonorrhea with Penicillin in Beeswax-peanut Oil, *J.A.M.A.*, **128**:404 (June 9) 1945.

[6] Moore, Joseph Earle: The Chemotherapy of Syphilis, *Am. J. Syph.*, 29:185-199, (Mar.) 1945.

[7] Penicillin Treatment of Syphilis. *Bull. U.S. Army M. Dept.*, 4:324-325, (Sept.) 1945.

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ABSTRACT: TRIDIONE FOR PSYCHOMOTOR ATTACKS

Tridione, a new drug whose effect on epilepsy is still being investigated, has brought spectacular results in some cases of psychomotor seizures, a condition in which mental disturbance is the principal feature of the attacks.

Writing in the March 2 issue of *The Journal of the American Medical Association*, Russell N. DeJong, M.D., from the Department of Neurology, University of Michigan Medical School and University Hospital, Ann Arbor, Michigan, says that thus far tridione has not proved to be sufficiently effective when used alone, partly due to the fact that most of the patients in his study were also subject to other types of epilepsy. These had been treated by anticonvulsant drugs, such as phenobarbital and the bromides, but in no instance were psychomotor attacks controlled by these drugs. The drugs were continued with the tridione, Dr. DeJong says.

Psychomotor seizures are characterized by loss of memory during which the patient may act like one who is intoxicated. The attacks may last only a few minutes, or they may go on for hours or days. While in this state the patient is morose and irritable and may become ugly or violent if forcibly restrained. Patients are often incapacitated by the attacks, and, as the result of the nature of the seizures, may require custodial or institutional care.

In conclusion, the author says that tridione used in conjunction with other anticonvulsants "has almost completely controlled the psychomotor seizures in a large percentage of the cases, and has resulted in a decided psychologic improvement."

SOME DIAGNOSTIC AND SEROLOGIC PROBLEMS IN THE PRESENT-DAY MANAGEMENT OF SYPHILIS

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Newer developments in venereal disease control have created or re-emphasized certain diagnostic and laboratory aspects in the management of syphilis which must be clearly understood. These developments include serologic testing placed on a compulsory and voluntary mass basis (premarital, prenatal, pre-employment, industrial, routine, diagnostic, blood donations, et cetera), introduction of rapid and intensive methods of treatment, advent of penicillin era, the return of military personnel from tropical and subtropical regions, and others. A few of the problems of particular importance to the general practitioner will be discussed in this paper.

I. Diagnosis of Syphilis After Penicillin Treatment of Gonorrhea

The successful eradication of syphilis largely will depend on the early recognition of the infectious primary stage. For this purpose the darkfield examination of the suspicious lesion represents the diagnostic procedure of choice. Penicillin is the first therapeutic agent known to be effective against both gonorrhea and syphilis. The coincidental occurrence of these two diseases is by no means rare. The disappearance of spirochetes following the administration of penicillin is remarkably rapid and may occur as early as seven hours after the treatment is started. Within twenty-four hours darkfield examination of the primary lesion usually fails to reveal any spirochetes. Even with small doses of penicillin, such as 1,000 units every three hours, there is early disappearance of the spirochetes although the rate is considerably slower.

What practical significance do these observations have? They indicate that the early infectious stage of syphilis may be masked or delayed due to coincident occurrence of gonorrhea treated with penicillin. If the darkfield examination is carried out following the administration of even small doses of penicillin the results may be misleading and the patient as well as the physician may acquire a wrong sense of security. Primary lesions may even heal, but the development of syphilis will not be prevented, as shown by subsequent occurrence of strongly positive serologic tests. The relatively small or moderate doses of penicillin effective against gonorrhea, but inadequate against syphilitic infection, may not prevent the development of the primary lesion, but may considerably prolong the incubation period. Cases are on record in which typical chancre appeared sixty days after the last intercourse. It is therefore essential that darkfield examinations be carried out before the administration of any penicillin. Since penicillin may prolong the usual incubation period and even cause the primary lesion to heal, the patient should have serologic tests done at intervals during the following three months. If these measures are not observed, there is a real danger, ironically enough, that with widespread use of penicillin for gonorrhea and other infections syphilis will increase due to masked appearance or delayed recognition of the primary infectious stage.

II. Effect of Newer Forms of Treatment on Serologic Tests and the Value of Quantitative Test

With the advent of newer rapid, semi-rapid intensive methods of treatment and the experimentation with penicillin the need for objective criteria of the immediate effectiveness of a given treatment became particularly apparent. To be sure, I am speaking only of the immediate effects. Long-range observation over many years will be needed for a final evaluation of any new form of treatment for syphilis.

The routine serologic tests are of very limited value in following up response to treatment, as their main value lies in the recognition of serologic reversal. But it has been shown that 99 per cent of the possible positivity of a syphilitic serum lies within the range of the so-called "4-plus zone."[1] This range includes sera containing just enough reagin to produce a clear-cut positive reaction, as well as those containing 10, 100, or 500 times that minimum amount. To recognize the decrease in the reagin titer under effective treatment before the serologic reversal, quantitative tests are essential. Any acceptable serologic test can be performed on a quantitative basis, designating as the titer the reciprocal of the highest serum dilution which still gives a clear-cut positive reaction. The results can also be reported in terms of "Kahn units," one unit of which is contained in that serum which in an undiluted state gives a 1-plus reaction. An undiluted serum giving a 4-plus reaction would contain 4 Kahn units, and, if still positive in a dilution 1:20 but negative in a next dilution, would contain 20x4=80 Kahn units.

What is the clinical value of the quantitative test? For routine diagnostic purposes it is usually of no value. Whether a positive serum contains 4 or 1,000 Kahn units is of no concern in the diagnosis. The 4-unit serum is just as syphilitic as the 1,000-unit serum. There is a great variation in the initial serologic titer of clinically similar cases.[2] The progressive decrease of the serologic titer under treatment is a favorable sign, whereas the progressive rise in the titer usually indicates a clinical re-

[1] Eagle, H.: *The Laboratory Diagnosis of Syphilis.* St. Louis, C. V. Mosby Co., 1937.

lapse. The question whether changes in the serologic titer, as determined by an accurate quantitative technic, actually predict the clinical course can be answered in the affirmative.[3] It is obvious that time necessary for a complete serologic reversal from positive to negative will depend on the kind of treatment given, as well as the height of the initial serologic titer. Much to the despair of the attending physician in some cases, particularly in late syphilis, it will be impossible to achieve a complete serologic reversal to negativity even after a prolonged treatment, considered as "adequate." Such cases, designated as "sero-resistant," "Wassermann-fast," or better—"reagin-fast" are the subject of frequent queries, but are usually dismissed by experts as meaningless. Some recent studies cast some doubt on the validity of this concept. Black-Schaffer and Rosahn,[4] in their recent study on syphilis, attempted to correlate blood serologic tests with anatomic lesions in three hundred thirteen autopies on syphilitic patients. They found that the anatomic lesions of syphilis were much more frequent in persons with positive serologic tests. The likelihood of syphilis being the primary cause of death was more than twice as great in syphilitics with positive as compared with negative serologic tests. Analysis of their data suggested a definite relation between increased activity of syphilis and the frequency of positive serologic tests. Further studies along these lines are highly desirable. Is our present concept of the so-called "adequate treatment" really adequate? A high percentage of the sero-resistant cases of syphilis can be shown clinically to have cardiac, neurologic, or visceral involvement. and available evidence suggests that persistently positive serologic tests usually indicate persistent foci of infection. With the advent of the more sensitive flocculation tests the persistence of positive serologic reactions occurs with increasing frequency.

III. Interpretation of Conflicting Serologic Reports—"S.T.S." of Choice

A source of considerable confusion to the practitioner is the laboratory report of conflicting serologic findings of multiple tests. Even if the clinician is familiar with the names of the authors, by which different tests are known (Kolmer, Kahn, Kline, Hinton, Eagle, Mazzini, et al.), he is usually at a loss to interpret such findings. He sometimes inquires as to which of the tests can be "trusted." To this, one must reply with Kolmer that "No test can be better than the laboratory conducting it."

The first serologic surveys conducted by the Indiana State Board of Health over five years ago, in connection with the approval of private laboratories for the performance of premarital tests, revealed a striking discrepancy in the results of the same serologic test on the same serum, as performed by different laboratories. Since that time many incompetent laboratories have been eliminated. Great progress has been made in the performance of serologic tests by serologic surveys and conferences conducted by the United States Public Health Service in collaboration with the American Society of Clinical Pathologists, as well as by intra-state serologic surveys, such as is conducted monthly by the Indiana State Board of Health. This resulted in the elimination of many tests either lacking sufficient specificity (many false positive reactions) or showing insufficient sensitivity (many false negative reactions). Those tests meeting rigid requirements, such as specificity of over 99 per cent, are often referred to as "approved." In Table I, I selected the nationally recog-

TABLE I

SENSITIVITY AND SPECIFICITY OF "APPROVED" SEROLOGIC TESTS

Name of Test	Sensitivity in Per Cent*	Specificity in Per Cent**
I. Complement—fixation tests:		
1. Kolmer, simplified	74.1	99.8
2. Boerner-Lukens	72.1	99.6
3. Mazzini	64.2	100.0
4. Eagle Wassermann	59.2	100.0
II. Flocculation tests:		
1. Mazzini	78.6	99.6
2. Eagle	72.1	99.8
3. Hinton	65.8	100.0
4. Kline, diagnostic	62.6	99.8
5. Kahn, standard	62.2	100.0
6. Boe ner-Lukens,		
Macroscopic	68.3	99.4
Microscopic	62.9	100.0

* As determined in 376 patients with all types of treated and untreated syphilis.

** As determined in 454 normal individuals and nonsyphilitic patients, excluding those with leprosy and malaria.

nized tests grouped as complement-fixation tests and flocculation tests, according to their sensitivity and specificity rating, as reported by the Committee on the Evaluation of Serodiagnostic Tests for Syphilis in 1942.[5] Since that time slight improvements in the technic of some of these tests would probably result in slightly different rating without essential changes. In the selection of a serologic test greater emphasis should be placed on

[2] Moore, J. E.; Eagle, H.: The Quantitative Serologic Test for Syphilis; Its Variability, Usefulness in Routine Diagnosis and Possible Significance. A Study of 1,665 Cases. *Ann. Int. Med.*, 14:1802-1814. (April) 1941.

[3] Simpson, M. W.; Rose, D. L.; and Kendell, H. W.: Quantitative Serologic Studies in Early Syphilis. *Ven. Dis. Inf.* 23:403-411, (Nov.) 1942.

[4] Black-Schaffer, B., and Rosahn, P. D.: Studies in Syphilis IV: Relation Between Blood Serologic Tests and Anatomic Lesions at Autopsy. *Am. J. Syph., Gonor. and Ven. Dis.* 28:27-43, 1944.

[5] Parran, T.; Hazen, H. H.; Mahoney, J. F.; Sanford, A. H.; Senear, F. E.; Simpson, W. M.; and Vonderlehr, R. A.: The Washington Serology Conference. *Ven. Dis. Inform.*, 23:161-195, (May) 1942.

its specificity, that is, its ability to react only with syphilitic serum in order to avoid a real harvest of unspecific false positive reactions. Kahn[6] has illustrated this point on a hypothetical case of forty thousand hospital admissions with one thousand two hundred cases of treated or untreated syphilis. If a sensitivity of a test is increased by 1 per cent, it will mean that twelve additional cases of syphilis will be reported as positive, whereas an increase in nonspecificity by 1 per cent will mean that four hundred nonsyphilitic will be labeled as syphilitic. I agree with those who prefer to miss an old case of latent, certainly non-infectious, syphilis rather than to wrongly label a single person as syphilitic. As seen in Table I, there is still considerable difference in the sensitivity of the "approved" tests, the Mazzini flocculation test being the most sensitive test, and the Kahn test considerably less sensitive but of slightly greater specificity. This fact alone would account for seemingly conflicting results in certain cases. The Mazzini test, e.g., becomes positive earlier and remains positive much longer following treatment. I have had frequent opportunity to observe that a doubtful or weakly positive Mazzini test with all other tests negative may be the sole remaining evidence of old, treated syphilitic infection, dating back twenty years or more. There is no one "best" serologic test for syphilis. Serologic surveys demonstrated the wisdom of performing two or more tests routinely. A sensitive flocculation test, such as the Mazzini test, with a high specificity, can be used to advantage as a "screening" test. If negative, no other test is indicated. If doubtful or positive, it should be confirmed by another flocculation or complement-fixation test. Possibly some confusion could be spared the general practitioner lacking the easy access to a clinical pathologist if the reports of multiple serologic tests could be summarized as the S.T.S. (S.T.S. is coming more into use as the abbreviation for "serologic test for syphilis.")

Table II illustrates the interpretation of some conflicting reports of two widely used flocculation tests of varying sensitivity. It is, of course, presumed that the tests gave essentially identical findings on repetition, and no inaccuracy or error occurred in the technical performance of the tests. Minor fluctuations in the sensitivity of the antigen and the amount of reagin occur from day to day, and if the reagin contents of the serum is small, this may account for seemingly confusing reports of the same test, such as negative, doubtful, weakly positive, et cetera. Such reports are, in fact, highly informative, indicating the presence of only a very small amount of reagin. On the other hand, some of the conflicting serologic reports may represent false positive nonspecific reactions.

TABLE II

INTERPRETATION OF DIVERGENT SEROLOGIC REPORTS

Mazzini Flocculation Test	*Kahn Standard Test*	*Interpretation (S. T. S.)*
Positive	Doubtful	Positive
Positive	Negative	Doubtful
Positive, Weakly	Doubtful	Positive, Weakly
Positive, Weakly	Negative	Doubtful
Doubtful	Doubtful	Doubtful
Doubtful	Negative	Doubtful
Doubtful	Positive	Positive
Negative	Positive	Doubtful (Non-specific?)
Negative	Doubtful	Doubtful (Non-specific?)

IV. Nonspecific or Biologic False Positive Reactions for Syphilis

Since the current serologic tests for syphilis, complement-fixation tests as well as flocculation tests are not based on a specific antigen-antibody reaction, it is, indeed, surprising how well they serve the serodiagnosis of syphilis. But positive reactions in diseases other than syphilis do occur, and the widespread routine use of serologic tests with numerous modifications in the technic renders the problem of recognition of so-called "false positive reactions" of great practical importance. Some excellent reviews of this subject are available.[7, 8, 9, 10]

For the general practitioner a detailed classification of these unspecific reactions is neither necessary nor desirable. That some spirochetal diseases primarily occurring in tropical or subtropical regions, such as yaws, bejel, and pinta, may give positive reactions as often as syphilis is easily understandable, for these diseases are caused by Treponemas closely related or even morphologically indistinguishable from Treponema pallidum and are called "syphilis-like" or "syphiloid" diseases. The reactions in these diseases are therefore better considered as true and not false positive. Aside from these three syphiloid diseases the false positive reactions can be divided into two main groups:

I. Technical false positive reactions.

II. Biologic false positive reactions.

The technical false positive reactions may be due to any technical inaccuracy, error, or break in proper technic from the collection of the specimen up to the actual performance of the test. They may range from such a gross error as wrong labeling

[6] Kahn, R. L.: *Serology in Syphilis Control.* Baltimore, Williams and Wilkins, 1942.

[7] Kolmer, J. A.: Problem of Falsely Doubtful and Positive Reactions in Serology of Syphilis. *Am. J. Pub. Health*, **34**:510-525, 1944.

[8] Rein, C. R., and Elsberg, E. S.: Studies on the Incidence and Nature of False Positive Serologic Reactions for Syphilis. *Am. J. of Clin. Path.* **14**:461-471, (Sept.) 1944.

[9] Davis, B. D.: Biologic False Positive Serologic Tests for Syphilis. *Medicine*, **23**:359, (Dec.) 1944.

[10] Beerman, H.: Biologic False Positive Reactions to the Tests for Syphilis. *Am. J. Med. Sc.* **209**:525-542 and **210**:524-548, (April and Oct.) 1945.

and mix-up of the specimen to the delicate task of shaking or mixing the antigen suspension. Their frequency is an index of the efficiency of a given serologic laboratory. They can and should be eliminated as far as humanly possible, and with further purification of the antigens used in current serologic tests another source of possible false positive reactions will be reduced to a minimum. The recognition of such reactions due to technical error is relatively easy by repeating the test.

The biologic false positive reactions offer a real problem and often tax to capacity the diagnostic acumen of the attending physician. I will not discuss the possible causes of such reactions, which is still a matter of controversial dispute. For the average clinician it is more important to keep in mind the diseases and pathologic states which may lead to unspecific reactions and to have some criteria for their possible recognition. At our present status of knowledge the list of the more important diseases and states which may predispose to biologic false positive reactions is as follows (in the approximate order of their frequency):

1. Leprosy.
2. Malaria.
3. Upper respiratory infections and pneumonia.
4. Infectious mononucleosis.
5. Smallpox vaccination.
6. Diseases associated with hyperproteinemia (such as lymphogranuloma venereum, kala-azar, et cetera).
7. A miscellaneous group of infectious and noninfectious states.

Leprosy and malaria are by far the worst offenders, and the frequency of positive reactions in leprosy has been estimated as high as 85 per cent. These diseases are usually excluded in the evaluation of serologic tests. The recognition of unspecific reactions following smallpox vaccination is of relatively recent date, but important in view of the mass immunization. These reactions usually occur within two weeks following vaccination and disappear after two to three months. I had an opportunity to observe strongly positive reactions to the Mazzini, Kahn, and Eagle tests on repeated occasions in a young girl who received smallpox vaccination sixteen days previously. The titer gradually diminished and serologic tests were negative nine weeks following vaccination. Great harm could have been done to this girl if she had been labeled as syphilitic and received treatment.

The important question arises: Do these biologic false positive reactions have any definite characteristics by which they can be recognized with certainty? Unfortunately, at the present time the answer is, "No." The serologic pattern of false positive reaction is variable. The important point to remember is that the majority of them are *transient* and *not* persistent. Many of them are of low titer and tend to become negative within a few days. But quantitative tests are not of much help. So-called "verification tests" did not prove of practical value, so far at least. But there is hope. Available evidence suggests that antibodies of true syphilitic serum differ from those of biologic false positive serum in certain physico-chemical and immunologic aspects. Studies are now in progress to develop a serodiagnostic method of differentiation based on these differences. Boerner recently proposed a new method for grouping and classifying serologic reactions for syphilis, based on flocculation and fixation of complement units, and this classification may be helpful in differentiation of false positive reactions from true syphilic reactions. Time and further experience are necessary for proper evaluation of this method.

Meanwhile, in the absence of a specific laboratory test for syphilitic or nonsyphilitic reagin the decision as to whether or not a patient with unexplained serologic reaction has syphilis is primarily the responsibility of the clinician. In many cases this will be a long and painstaking task best carried out in consultation with the clinical pathologist. To lean on the social status of the patient will only result in a situation so pointedly described by Stokes: "There are instances in which one Wassermann test will convict a laborer over his own denial; two will make a case against a banker or a railroad president; but three successive positives will scarcely convince the medical adviser of the 'guilt' of a clergyman." Stokes, et al., recently published the results of a carefully conducted and interesting investigation of nonspecific reactions based on examination of 210,261 Red Cross donor bloods.[11] Of seventy-nine essentially unselected donors with positive serologic tests submitted for extended special studies, only 40.5 per cent were finally adjudged by a competent reviewing board to have syphilis. The time required for a decision was less than three months in 69.2 per cent of the syphilitic, and more than three months in 78 per cent of the nonspecific positives. History and physical examination contributed little to differentiation of syphilitic and nonspecific reactions. The detection of previously undiagnosed latent syphilis is at present done largely by serologic methods. The authors recommend that doubtful cases be kept under prolonged observation. Even at the end of a year the diagnosis may still be undetermined.

The following points may be helpful in the investigation of nonspecific false positive reactions:

Suspect false positive reaction if:

1. A more sensitive test, such as Mazzini, gives a negative reaction; whereas a less sensitive test, such as the Standard Kahn test, gives a positive reaction.

2. A positive reaction is obtained in one laboratory, and negative reactions in all others.

[11] Stokes, J. H.; Boerner, F., Hitchens, A. P.; and Nemser, S.: Nonspecific Reactions in Routine Blood Testing for Syphilis. *J.A.M.A.* **130**:57-60, (Jan.), 1946.

3. There are continuously weak or doubtful reactions with a sensitive technic.

4. The titer progressively drops without treatment.

5. There are serologic discrepancies between tests, particularly between flocculation and complement-fixation tests.

In the study of questionable cases, proceed along the following lines:

1. Repeat S.T.S. by several different technics, one of which should preferably include a complement-fixation test. In strongly positive reactions the quantitative titer should be determined.

2. Obtain a particularly detailed history, repeating questions regarding symptoms of syphilis and antisyphilitic treatment again and again. Inquire regarding malaria, recent (within a month or so) colds, sore throat, febrile sickness, pneumonia, or smallpox vaccination.

3. Make a thorough physical examination including examination of eyes with slit lamp (vascularization of cornea!), skeletal charges (tibia!), reflexes and stripped examination of skin for rashes.

4. Make a roentgenologic examination of heart and aorta.

5. Examine blood smear for evidence of malaria parasites and infectious mononucleosis (a common disease!).

6. Institute a serologic follow-up at regular intervals without antisyphilitic treatment, using, if possible, a quantitative technic. Several months may be required for a final decision.

7. If results are still inconclusive, make a spinal fluid examination.

By such or similar routine as suggested by Moore, Stokes[12, 11] and others, and a close collaboration between the clinician and the clinical pathologist, a decision can be reached in the majority of cases, sparing the patient mental trauma and prolonged treatment for a disease which he does not have.

SUMMARY

Newer developments in the control of syphilis created certain diagnostic and serologic problems. The diagnosis of early infectious syphilis may be masked or delayed by penicillin treatment of gonorrhea. The introduction of newer methods of treatment of syphilis emphasizes the importance of adequate serologic studies for evaluation of a given therapy. The value and limitation of quantitative serologic tests and the interpretation of conflicting serologic reactions have been discussed. There is no "best" serologic test for syphilis ("S.T.S."). No test can be better than the laboratory conducting it. The wisdom of performing multiple tests in the serodiagnosis of syphilis is established. The problem of nonspecific, false positive reactions for syphilis is of great practical importance and can be best solved by co-operation of the clinician and the clinical pathologist. Some criteria for recognition of unspecific reactions have been outlined.

[12] Moore, J. E., Eagle, H., and Mohr, C. F.: Biologic False Positive Serologic Reactions for Syphilis: Suggested Method of Approach to their Clinical Study. *J.A.M.A.* 115:1602-1606, (Nov.) 1940.

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PENICILLIN IN THE TREATMENT OF CONGENITAL SYPHILIS

This is a preliminary report on twenty-nine infants and children with congenital syphilis treated by penicillin. Two types of patients were treated, (1) those with early congenital syphilis, previously untreated, whether clinical manifestations were present or not, and (2) those with late congenital syphilis, treated or untreated, but with definite clinical manifestations. The first group received 20,000 O. u. per kilogram of body weight, given in 60 intramuscular injections every three hours for seven and one-half days. The second group received a total dosage of 20,000 to 60,000 units per kilogram over a period of ten to twenty days. The quantitative Kolmer complement fixation test was used for all patients.

The most satisfactory results were obtained in cases of early congenital syphilis with manifest symptoms, in which skin eruptions healed within twenty-four to forty-eight hours after therapy, and lesions disappeared by the end of the seven and one-half days of treatment. In patients with asymptomatic early congenital syphilis, no clinical evaluations were possible, but a gradual decrease in the titer of the blood was observed in three of four patients.

In late congenital syphilis, interstitial keratitis seemed to be definitely improved in four of six cases, but in the children with neurosyphilis who were suffering from juvenile paresis, no changes in serologic tests or clinical improvement was noted. One girl with hydrarthrosis of one knee developed a similar condition in the other knee, and five days after the second course of penicillin a typical interstitial keratitis appeared.

In spite of the favorable results observed in cases of early manifest syphilis, it is stated that the over-all effectiveness of penicillin in the treatment of congenital syphilis leaves much to be desired. The most logical method of attacking the problem of congenital syphilis is its prevention by the diagnosis and treatment of syphilis in the pregnant woman.

—*Texas State J. Med.*, Fort Worth, 41:401-404, (Dec.) 1945.

SEROLOGIC TRENDS AND ASPECTS

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INDIANAPOLIS

The importance of serologic tests as an aid to the diagnosis and treatment of syphilis can hardly be overestimated, but good judgment in their use and interpretation is of equal importance. In the course of syphilitic infection a substance known as "reagin" appears in the blood stream. The principle upon which all tests for syphilis are based is that reagin has the property of combining with finely-divided particles of normal tissue lipoids, known as the "antigen." The combination of the two substances results in the clumping of the lipoidal particles to form visible floccules. This aggregation is used as the diagnostic criterion in the various flocculation tests, such as the Kahn, Kline, Eagle, Hinton, and Mazzini. In the case of the so-called Wassermann test, the "reagin-lipoidal" combination is able to fix or bind another substance, known as "complement," and this phenomenon forms the basis for that test. While these lipoidal antigens are not true antigens in the biologic sense, they do react in a remarkably specific manner with syphilitic serums, but although most positive serologic reactions are due to syphilis, it is also true that some positive results are unrelated to syphilis and represent what is now known as a biologic false positive reaction. Therefore, the term "positive" as applied to serologic results does not necessarily mean syphilitic disease, and it certainly does not indicate infectiousness.

Within recent years it has been shown that syphilis is not the only disease which causes human serum to react with syphilis antigens. There are some diseases, disease conditions, and several factors other than syphilis which may cause false weakly positive reactions, and even strongly positive reactions. Consequently, in arriving at a conclusion as to the presence or absence of syphilitic infection, or as to the significance of the serologic results of a patient under antiluetic treatment, the physician must correlate the laboratory report with the clinical findings. Likewise, the physician should become familiar with the many sources of error, with the limitations of the tests themselves, and with the conflicting views as to the meaning of serologic findings. From unpublished experimental data the author is of the opinion that aside from the lipoids which have the power to unite with reagin other substances (possibly closely related lipoids) are extracted simultaneously from normal tissues which possess the ability to react with antibody-like substances present in disease and disease conditions other than syphilis, such as leprosy, malaria, virus pneumonia, mononucleosis, postvaccination, acute respiratory infections, and perhaps many others. This antibody-like substance may be designated as "bioreagin" meaning biologic reactor, to distinguish it from reagin, the syphilitic reactor.

While many attempts have been made to develop a "verification" or "differential" test in the hope that it may distinguish between the true syphilitic and the false positive biologic type of reaction, they have, thus far, ended in partial failure due chiefly to the observation that, in very early syphilis and in long-treated syphilis, reagin is apparently indistinguishable from bioreagin. It is very likely that the globulin contained in reagin is, in the early stages of the infection, identical to bioreagin, and that as the infection progresses it becomes altered or denatured to form reagin. Conversely, in long-treated lues reagin becomes denatured and reverts to bioreagin. For this reason too much confidence should not be placed on verification or differential test results in those individuals whose syphilitic status is in doubt.

Recent investigations have shown that certain individuals are more likely than others to develop false positive blood tests for syphilis. Furthermore, there seems to be no apparent relationship between the severity of the disease and the development of false positive serologic reactions. Some patients with severe and prolonged involvement may remain seronegative, while others with a mild course develop false positive serologic reactions for syphilis.

Two types of false positive reactions must be distinguished: (1) the technical or laboratory error; and (2), the biologic false positive. The technical or laboratory sources of error include: bacterial or chemical contamination, mislabeling of specimens in the laboratory or in the physician's office, the use of lubricants in syringes, insufficient skill and experience of technicians, improperly-prepared glassware, faulty reagents, and clerical errors. The biologic false positive is that encountered in the absence of syphilis. It represents an actual substance present in the blood serum of certain individuals having nonspecific diseases; indeed this condition is occasionally found in presumably normal individuals showing not the slightest indication of any pathologic process. The following diseases and disease conditions have been shown to give false positive reactions: leprosy, malaria, virus pneumonia, acute upper respiratory infections, vaccinia and infectious mononucleosis. The following may give false positive reactions, but usually the reactions are weakly positive: tuberculosis, pregnancy, malignancy, serum treatment, and hyperpyrexia.

In view of the above findings, it is, therefore, essential to be cautious in the interpretation of the results obtained, but one should always keep in mind the possibility that a patient with positive

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serology may have both syphilitic infection and a concurrent disease, such as mononucleosis or malaria. The serologic management of a suspected case of biologic false positive should be, first, to repeat the test to exclude laboratory errors; if the test is still positive, to exclude the existence of some acute nonsyphilitic condition. In the event that the reaction is four plus, a quantitative test should be requested and followed by quantitative determinations at two- to four-week intervals. The following test procedures should be done whenever indicated: heterophile antibody, blood smears for malaria and infectious mononucleosis, verification or differential tests, and sedimentation rate. When dealing with suspected cases of biologic false positives it is preferable to employ more than one test. Some tests are more apt to be positive than others in certain diseases, such as the Kahn test in malaria, the Hinton and Mazzini tests in vaccinia, and the Kolmer-Wassermann test in mononucleosis. It should also be clearly understood that there is not any one test which will not, sometime or another, produce false positive reactions. In the investigation of a suspected case of biologic false positive the time element is essential. Depending on several factors, the reaction may remain weakly positive for months before finally reverting to negativity. For this reason the periodic blood examination should not be oftener than two to four weeks. As shown in Graph IV, the antibodies may remain in the circulation long after the causative agent has been withdrawn or removed. It is of the utmost importance during the investigation to determine whether or not a given case is a true biologic false positive that no specific therapy be given, since such a procedure would obviously vitiate the entire study.

During the last few years quantitative determination has been overly emphasized with the result that its use has become indiscriminate. The employment of quantitative tests is of value only under certain conditions, and proper evaluation of the results is necessary if misleading interpretations are to be avoided. In the first place, quantitative procedures are not aids to diagnosis. A patient with a low titer is not less syphilitic than one with a high titer. In fact, in some stages of syphilis a few Treponema pallida giving rise to a small quantity of reagin detected by serologic tests at 2 plus, for instance, will, nevertheless, produce such serious physiological changes as to incapacitate the individual, while in late primary and early secondary the production of reagin may be enormous, say 600 units, yet the individual is in apparently good health. Secondly, the prognostic significance of quantitative determinations in patients undergoing treatment is very questionable. Many patients showing a successively downward trend, and even after attaining complete negativity, may and do suddenly relapse clinically and serologically. Quantitative tests are indicated in (1) evaluating the efficacy of new drugs; (2) in seroresistance, also known as Wassermann fastness, and more properly designated as reagin fastness; (3) in suspected biologic false positive reactions showing not less than four plus; and (4) in serologic follow-up of infants born of syphilitic mothers.

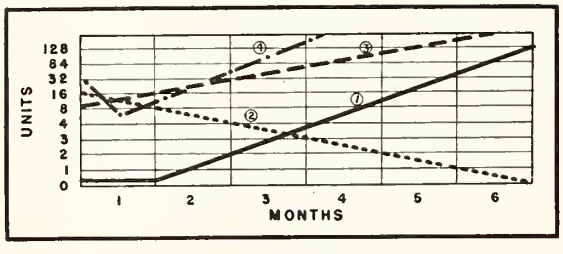
Only a progressive rise in titer is of significance. A temporary upsurge, while it may be caused by an increased amount of reagin, is more often due to technical errors. For example, in the performance of the Kahn quantitative test the highest dilution which reacts positively is then multiplied by four and reported in terms of units. Thus, if the highest dilution, let us say 1:10, is found positive, then the number of units to be reported will be 40. If, however, the specimen is split and tested separately by the same technician, it may be found that the second portion of the specimen is read as a doubtful reaction in the dilution of 1:10, and since the next smallest dilution is the 1:5, only 20 units will be reported. This is an instance of an error which may be several-fold, depending on the acuity of the individual. The difference between a positive and a doubtful or between a doubtful and a negative is, at times, so slight that not infrequently a single specimen submitted on the same day to the same technician, but divided into several portions, will give discordant results. A second source of error in quantitative determinations, which is, however, unavoidable, is the biologic factor. Fluctuations in the titer may occur due to the appearance of bioreagin as the result of an intercurrent illness. A third source of error is that due to variations in the sensitivity of the antigens whenever a new lot is employed. Still another source of confusion and misinterpretation lies in the particular method employed in reporting a quantitative reaction. As mentioned previously, the Kahn method is to multiply the dilution by four, while nearly all other technics report the actual dilution in terms of units; thus, a positive reaction in a dilution of 1:10 is reported as containing 10 units, which corresponds to 40 Kahn units, yet both reactions are positive in the same dilution. The use of quantitative procedures is of no particular value in the treatment of syphilis by ordinary methods, since in many instances it imparts a false sense of security, as previously stated. Besides, there may be quite frequently unexpected and sometimes unexplainable rise and fall of the titer. Furthermore, the initial serologic titer is of no significance in the prognosis of syphilis because the variations encountered are too great. In a group of three hundred patients treated by the massive dose arseno drip therapy method of Dr. George W. Bowman's series,[1] it was found that thirteen cases having titers varying up to 240 units became negative in one month, while eleven cases with titers up to the same number of units became negative in six months. There were twenty-five cases showing varying titers up to 160 units which became negative in two months, while eleven cases having titers up to the same number of units became nega-

[1] Bowman, George W., and Sheehan, Francis: Massive Arsenotherapy in Syphilis. *J. Ind. St. Med. Assn.*, Vol. 34, No. 12, pp. 665-669 (Dec.) 1941.

tive in five months. From the serologic behavior shown in this and other series, it may be concluded that a patient with an initial titer of, let us say, 240 units may become seronegative months before another patient whose titer is only 20 units.

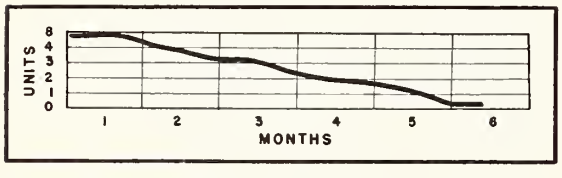
Graph I represents several possibilities of an infant born of a syphilitic mother. Line 1 shows that the reaction may be negative at birth, continue to be negative for a time, then show a progressive rise in titer due to the development of reagin as the result of a late spirochetal invasion of the fetus. Line 2 shows that the reaction may be positive at birth, but the infant may be nonsyphilitic. Quantitative tests will reveal that the 16 units of placental-transferred reagin gradually decrease, and in this hypothetical case become negative in six months. Line 3 shows that the reactions may be positive at birth and that the infant may be syphilitic. Born with 8 units of reagin the infant's blood serum progressively rises to 128 units. Line 4 shows that the reaction may be positive at birth, decrease for a time, then progressively rise. The explanation in this case is that both reagin and Treponema pallida had been transferred from the mother. The mother's reagin accounts for the initial decrease, and the infant's own reagin for the subsequent rise.

GRAPH I.



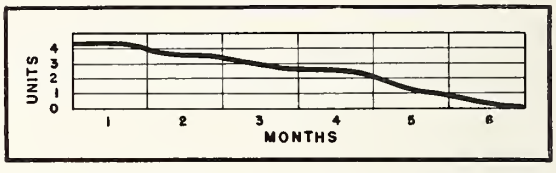
Graph II represents a case of biologic false positive reaction with an initial titer of 8 units. A gradual decrease without specific therapy to negativity was accomplished in six months.

GRAPH II.



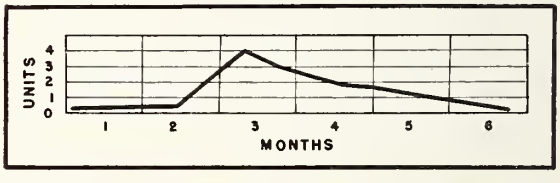
Graph III represents the immunization of a seronegative animal by means of a sufficient number of injections of a mixture of lipoidal extract and normal serum to render the animal's blood serum four plus by serologic tests for syphilis. At the end of this period the injections were discontinued and monthly serologic tests for syphilis performed. As may be seen from the graph, the initial titer of four plus gradually decreases and attains complete negativity in six months. But the real purpose in presenting this graph is to demonstrate that antibodies may and actually do remain in the circulation for months after the causative agent has been withdrawn or removed. The analogy of this nonspecific, antibody-like substance which reacts positively with serologic tests for syphilis and the presence of bioreagin in an individual having a biologic false positive reaction may be readily understood, both in its probable manner of production and the time element before its disappearance.

GRAPH III.



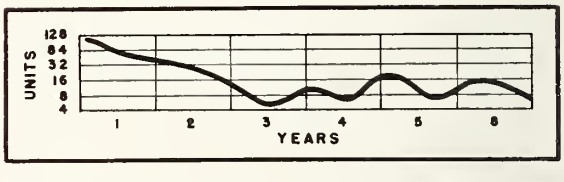
Graph IV represents a case of a seronegative latent syphilitic having an intercurrent illness which was responsible for his temporary upsurge. Similar rises may obtain whenever an inciting agent causes bioreagin to appear in the blood stream.

GRAPH IV.



Graph V represents a case of seroresistance (Wassermann or reagin fastness). Quantitative determinations performed from the beginning of therapy reveal that actually there has been considerable serologic improvement as seen from the initial number of units, but for the last three years the serology has remained somewhat static with occasional temporary upsurges in spite of adequate treatment. This patient, in all probability, never will become seronegative regardless of therapy. The temporary upsurges may be the result of differences in the sensitivity of the tests used or of intercurrent diseases. While serologic cure may be of great moral (?) importance to the patient, symptomatic cure is of far greater practical importance to the clinician and the patient, if the latter is properly advised.

GRAPH V.



VENEREAL DISEASE

GERALD F. KEMPF, M.D.

INDIANAPOLIS

Syphilis, gonorrhea, and all forms of gonococcal infections, chancroid, lymphogranuloma venereum, and granuloma inguinale are the venereal diseases that should be reported to the State Department of Health. These are the diseases that presented serious difficulties to the military authorities and the personnel of the armed forces. With these diseases prevention presents a somewhat different problem than the ordinary communicable disease. In such diseases, immunization, treatment of the infected patient, quarantine, or isolation of the infected person, quarantine of contacts during the incubation period, eradication of the sources of infection and controlling the vehicles that spread the disease are the usual means of prevention.

Immunization is a highly-effective means of control when a method is at hand such as vaccination against smallpox. Control of food and water supplies are highly-effective measures in the control of typhoid fever. Unfortunately in venereal diseases there is no method of immunization, no vectors to control, and nothing inanimate that might be amenable to sanitary measures.

The mechanics of spread in all of these diseases is a direct one from person to person in all but occasional cases, for the simple reason that the causes of these diseases remain viable away from the human body for only a very short time. This means then that there are only two real means of controlling these diseases: first, isolation of the infectious patient; and second, treatment that will render the patient noninfectious. One factor that compares with secondary spreaders of other diseases may be represented here in the example of the prostitute who may actually be a vector before she contracts the disease. The type that has twenty or more daily contacts may easily infect several others following the deposit of infectious material in the vaginal tract, where the organisms must necessarily remain viable if the individual herself is to later contract the disease. This illustrates why examination of segregated prostitutes has always been a failure as a preventive even if one could detect these diseases during the last stages of their incubation period.

There is little doubt that the weapons or combination of weapons for rendering patients with syphilis and gonorrhea noninfectious are at present in our hands if we use them wisely and well. There is also little doubt that incomplete treatment of either of these diseases causes a false sense of security in the patient and the contact and thus results in a spread of the disease. This is a serious matter, but not more serious than the fact that such practices jeopardize the weapons themselves by producing resistant organisms. There is not much defense for treating a large group of promiscuous women with a few shots of penicillin, totally ignoring the fundamental facts concerning the time factors in its action in order to get their cooperation in coming to the clinic for a short period of treatment.

The educational program that soldiers were and are given in the service has infiltrated to the public to the extent that the infected men immediately seek the advice of their physicians because they are sick. Unfortunately, the women have not in such large numbers received this indoctrination. During the short existence of the Indianapolis Public Health Center there has been a definite and concerted effort on the part of the physicians, nurses, social and educational workers, and the investigators to give these patients the idea that they are ill and in need of treatment. Every effort is made to have them understand that the best thing for any one having a venereal disease is to place themselves under a doctor's care. An attempt has been made to remove not only the stigma from the disease, but also the stigma from the institution. That this has succeeded to a considerable extent is evidenced by a decrease in delinquency of patients returning for tests, the rarity of escapes in spite of abandonment of constant police supervision, and the increase in the number of voluntary patients reporting for examination.

The police department has cooperated, and every effort has been made to avoid the stigma and the surroundings in the jail. In order to accomplish this, we have had to accept patients without a prior diagnosis, and we have had to agree to return these people to the courts. Since these people would rather be in the health center than in jail, we have not had any law suits or habeas corpus proceedings for a year. Attorneys have come to recognize that their clients are receiving good treatment and necessary check-ups. Many patients come to the center when advised by police officers to do so rather than experience arrest. This has been a very important factor in our local program.

The investigators here have also been instructed not to expect the Police Department to do their venereal disease investigations. Only when these officers are unable to get the patient's cooperation with written as well as verbal notice are police summons issued. A few individuals with communicable diseases will always have to be managed in this way. Proper investigation has also aided in preventing some doctor's patient from being embarrassed by a police call.

The first aim of the state and local program is to prevent spread of infection by confining those diseased known to be incorrigible, promiscuous, or those in close contact with children and those

unable to house themselves properly during the infectious stage. Legally, anyone suffering from a communicable disease can be isolated or quarantined, but treatment can not be given without the consent of the individual, parent or guardian, or without the order of a court. Every effort is made to send those who are cooperative and who can afford the care to their own physicians. Consideration here is given to the patient's actual ability to avoid spread during the infectious stage and to his actual willingness to cooperate with his physician. Some must necessarily be treated in the center during the infectious stage and then sent to a private physician. Some patients are sent to the center by private physicians who definitely want the particular patient treated because hospitalization is not then available; the patient is definitely infectious and circumstances best known to the physician warrants recommending immediate treatment in the center. Only those definitely infectious are taken under these circumstances. This has never been abused.

An arrangement for care in such institutions by private physicians when the patient is able to pay them would be highly desirable if the grant of funds would permit the hospital to charge a commensurate fee. There should be some means by which patients in moderate circumstances could be hospitalized without depriving them of the services of the physicians of their choice. The question of proper therapy could readily be governed by requiring the treatment to follow approved standards with such additional measures deemed necessary by the practitioner.

Certain facts regarding the handling and disposal of patients, infected and noninfected contacts, are important to the physician and the general public. Early in the war the chief sources of the cases were from military authorities and from the police. With the end of the war and the resulting return of veterans a large percentage of patients are voluntary. At present every effort is being made to get reports of contacts from each patient seen by the members of the clinic staff and by private physicians. Our purpose is primarily to get all of these contacts examined by private physicians, or if unable to care for themselves, at the clinic. Most can be prevailed upon to come in for examination. Certainly with gonorrhea in which the incubation period is short, contacts should readily be traced in various directions. Syphilis with its longer incubation period sometimes is more difficult, especially if it arises in a person whose exposure was to both gonorrhea and syphilis and whose gonorrhea was treated with penicillin with its resultant effect on the length of the incubation. When contacts are elicited in all directions one should and does find overlapping of contacts with one or more promiscuous sources.

Other sources are premarital tests, pre-employment tests, food handlers' tests, routine hospital tests, and so forth. If in all of these cases contacts were reported and investigated the attack rate would remain low. Our present policy on receipt of such report is to find out if the patient is at present under the care of a physician. Since our purpose is to get infectious patients under treatment, these are let alone unless the doctor reports them as uncooperative. The present policy of the armed services is to release soldiers even though they have inadequately treated syphilis, and the veterans facilities are not accepting patients with syphilis or gonorrhea on the ground that these infections are due to misconduct. If the illness requires immediate hospitalization the patient is accepted, but infectiousness is not one of the criteria for determining urgency. The veterans who come or are sent to the center expect treatment and resent the suggestion that they go to a private physician. Probably the only solution will be that the veterans' facilities treat these people as outpatients as a matter of policy, or, much better, definitely tell them that they are expected to provide their own care for such illness. The veterans are cooperative as a rule in naming the probable sources of their infections.

Early difficulties in this setup arose from too great tendency to rely solely upon the police. Much better results have been obtained from expecting venereal disease investigators to do their own infected and noninfected contact tracing, and by expecting these investigators to bring the patients in by persuasion because they are diseased rather than criminals. Only the definitely recalcitrant need be brought in on a health summons. Instead of turning the names of all the individual contacts over to the police, having them look after the places of most frequent exposure and reporting the sources of call girls or prostitutes appears to get better results. All of our efforts need be directed toward educational work to teach people how to avoid the diseases, and what to do if they get them. A great deal of this educational program must be directed toward the teaching of social and psychological adjustment. To keep people in jail while establishing a diagnosis is certainly inconsistent with efforts directed toward removing the stigma and getting the patient's cooperation.

Following demobilization in other wars, there has been a general increase in the attack rate, usually about fifty per cent. With the improved educational program of the armed forces this increase may be less, but already an increase in syphilis has been noted. The rapidity with which patients with gonorrhea can be rendered noninfectious has probably affected the decrease in the general incidence of this disease. With syphilis the long incubation period permits an opportunity for a larger number of contacts before someone names the source. Obviously, the disease is not as readily transmitted as gonorrhea.

Last year 5 to 6 per cent of all venereal cases were syphilis, 86 to 93 per cent were gonorrhea, and the remainder chancroid and lymphogranuloma venereum; this year the cases have risen to 16.4 per cent syphilis as against 82.9 per cent gonorrhea. During the last year 1,063 referrals to

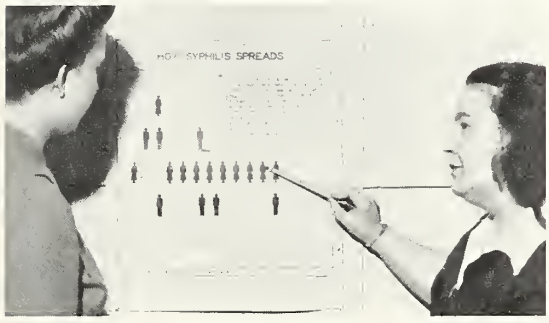
the Indianapolis Health Center of more than 4,000 have come from the State Health Department alone. Since July, 1944, this center has received 7,937 complaints and reports of suspected venereal disease. This is an everage of 360 cases monthly, and during April, 1946, the number reached 477, an increase of 16 per cent over the highest previously-reported total. The distribution of these was as follows: 110, or 23 per cent syphilis, with 30 given five-day therapy at the City Hospital; 50 treated at the Public Health Center; 17 sent to private physicians, with 9 already under treatment elsewhere; 94 gonococcus infections of which 79 were treated at the center; 11 sent to private physicians and 4 already under treatment; 59 were separatees with positive or questionable serological tests for syphilis who are being followed but are not under treatment at present; 49 were completely negative; and 165, or 34 per cent of the total, could not be located principally because there was insufficient information. The investigators brought 11 infectious cases of syphilis under treatment here and sent 7 to their own physicians. Three patients with gonorrhea were brought to treatment at the center and 7 were sent to private physicians. During 1945 the number of secondary contacts sent to private physicians exceeded the number treated in the Public Health Center. Naturally most of the original cases reported here and their contacts are in the lower economic brackets or are not presently employed. Recently there has been a definite increase in the number of cases attributed to call girls and street walkers. A large percentage of exposures are occurring in hotels, cabins, and rooming houses. Unfortunately the percentage of the complaint of failure to name the place of exposure has almost doubled.

Until recently the information on the complaints from military authorities was quite complete and really serious efforts were made to locate all sources. For some reason as high as 40 per cent of the complaints are so completely lacking in information as to name, address, and description as to be completely worthless from the standpoint of control or prevention.

Much of the usefulness of this program lies in removing from circulation infectious cases of venereal disease. There has also been a change in the attitude of the general public which is reflected in the earlier appearance of the patients in the doctors' offices and their attitude toward treatment.

HOW SYPHILIS SPREADS—OR CASE FINDING

A physician in a middle-western city asked the State Health Department to trace the source of infection in 3 cases of newly-acquired infectious syphilis in his practice, all men (Group II.). The infection of all was traced back to 1 woman, a prostitute (Group I.). Then the inquiry turned to persons whom these men might have infected. It was discovered that 1 man had infected 1 girl, and another man 9 girls, of whom 6 were under 18 years of age (Group III.). Of these, 4 girls in turn infected 4 other men (Group IV.). In all, 24 persons were examined and 18 were found infected and placed under treatment.



ABSTRACT: PENICILLIN EFFECTIVE IN EARLY SYPHILIS

Major William Leifer, of the Army Medical Corps, reports that penicillin, administered over an eight day period, was effective in curing early syphilis among Army personnel.

His study, based on ninety-six patients, is reported in the December 29 issue of *The Journal of the American Medical Association*. Major Leifer stated that the patients received sixty injections of 20,000 units of penicillin in a salt solution at three-hour intervals. The total dosage was 1,200,000 units injected into the muscles because this method delays the absorption and excretion of the penicillin better than when it is injected into the veins.

An inflammatory reaction occurred in eighty-eight patients, or 91.6 per cent, during the first day of treatment. But the author pointed out that "in no case was it necessary to suspend or interrupt treatment because of reactions."

Major Leifer reported little success with penicillin treatment in secondary syphilis. He felt, however, that "results in secondary syphilis can be improved by increasing the size of the individual dose of penicillin, by lengthening the course of treatment, or both."

The author concluded that "the effectiveness of a given treatment schedule must be judged by the incidence of relapse, which is greatest in the first six months after treatment, and by prolonged observation of patients to make certain that early satisfactory progress is maintained permanently." A relapse was observed in only eight of the ninety-six patients, and seventy-one patients continued to progress satisfactorily after twelve months of observation.

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JUNE, 1946

Editorials

SELECTIVE SERVICE AWARDS

Thousands of physicians throughout the country, men for the most part above "service" age, made a notable contribution to the war effort through the assistance they rendered to the Selective Service System, all with reward or hope of reward. Similar services have been rendered by a perhaps lesser group during World War I, and those contributing to the effort received no official recognition for such services. Hence, the recent recognition that has come to this group is, indeed, most welcome.

The "award" consists of a medal, with appropriate ribbon, bearing on the one side the inscription, "Selective Service System, World War II," and on the reverse a notation that the medal is issued by Act of the Congress of the United States. In addition, there is a "ribbon" lapel button, to be worn by the recipient. A "Certificate of Merit," issued through Congressional action, is also given to all who participated in this program.

A letter was sent out, asking those interested in just what manner this award should be made; should there be a state-wide meeting called and a formal program arranged; should such a program be followed in the various counties and districts; or should the awards be sent via the mails? Most doctors still are busy, and it is not at all surprising that the vote on these questions was almost unanimous that the awards be mailed and that no effort toward general publicity be given the event.

However, it is the plan of the Service, after all have received their awards, to arrange for publication, in the local press in every district, the names of those so honored.

The action of the Selective Service System in this connection will, we are sure, meet with general approval, not only from those who participated in the program, but from the American people. The medical profession played a very important role in the winning of the great war, this fact being generally recognized. And, not only is credit given to those who served in the armed services, but to those who remained on the home front, rendering services to civilians, aiding the Selective Service program, and what not.

Now we have something tangible to show for our efforts—we have the medal, the button, and the certificate—all very important mementos of our part in the war.

After the close of World War I there were many who, having done their bit-plus even though they remained at home, felt that a wee bit of recognition would not be amiss, but it was not forthcoming. Probably somewhere in the war archives, down in Washington, there is some record of the names of those of us who served on the Draft Boards, the Advisory Boards, and the State Councils of Defense, yet we have no personal reward for our contribution at that time. Now we have a definite award, one that, in so far as we are personally concerned, goes right into our "treasure box," where things important to us are to be placed. We want our grandchildren, when looking over their Dad's medals, service ribbons, discharge paper, et cetera, to be able also to look over Grandad's awards.

Yes, we are mighty proud to have these little memory boosters, mighty proud to know that the Government of the United States has *officially* recognized the fact that a lot of folk, even though not engaged in actual battle, did a most important job in the winning of the war.

VOX POP

The origin of many sound suggestions appearing in state medical journals and county society bulletins can often be traced to ideas germinated in "grass roots" meetings and discussions in the so-called "hinterlands." It may appear at times to busy practitioners that their interest and active participation in the medical and economic affairs of the state organization is wasted. Progress toward desirable objectives is slow. The "little fellow" may feel that his is a voice crying in the

wilderness. Many of his suggestions may be ignored. Many survive, however, and are translated into matters of adoption and organization policy. The important element is that the members throughout the state have an opportunity to speak their minds in state or county meetings or through the pages of THE JOURNAL.

Various state and county publications, in an effort to bring out worth-while topics, have set aside a page for letters of criticism, suggestions, and expression of ideas. In most instances this practice has been abandoned because of lack of response from the membership.

Comes now a gentleman from Indiana who inquires in the pages of *Medical Economics*, "How can the individual doctor get a hearing?" He complains that in our state, for example, there are no 'letters-to-the-editor' pages in THE JOURNAL . . ." and he offers, as a solution, "more medical journalistic 'town halls' where all viewpoints can be presented."

Although not original, this is a very valuable suggestion. It has been tried and found wanting by innumerable state and county periodicals simply because the average doctor, who may have an idea, an opinion, a suggestion or a gripe will not take the time to sit down and write it and send it to the editor. Yet it is so worth while that every editor would welcome the opportunity to cooperate in presenting such material to the members of his organization.

So this is by way of hoisting a trial balloon. Do you want a page or more of "letters-to-the-editor" with appropriate answers? The response to this inquiry will determine the policy. If the desire is sufficient, you write 'em and we'll print 'em.

INDIANAPOLIS MEDICAL SOCIETY PLAN

For some time past it has been recognized that a stopgap exists in the matter of immediate treatment of many war veterans here in Indiana, as well as elsewhere throughout the country, this being due to lack of available hospital facilities and the shortage of manpower in our present hospitals. It was announced quite some time ago that a new veterans' hospital was to be erected in Indianapolis, in the immediate vicinity of the Indiana University Medical Center, but through many of our post-war problems this project has been slowed up, although it now appears that work soon will be begun on the building.

In the meantime the "case load" has continued to mount, and "what to do about it" became an acute problem. This appears now to be at least partially solved by a plan evolved by the American Legion, the Veterans Administration, the City of Indianapolis, and the Indianapolis Medical Society working closely with the Indiana University School of Medicine, whereby Billings Hospital, at Fort Benjamin Harrison, will be opened up to the Veterans Administration.

The members of the Indianapolis Medical Society, plus the teaching staff of the medical school, will materially assist in the treatment program to be installed at Billings Hospital, each man serving a certain number of hours per week in this work. This, of course, means an additional load on the medical profession of Indianapolis and vicinity, but the job must be done and done at once. Plans are in the making for an immediate start on this new program.

It also is planned to speed up the construction of the new Veterans Hospital, some twenty acres near the medical center having been donated for the site by the City of Indianapolis. One of the Indianapolis papers, in commenting on the program, remarks, "Readiness of local doctors to cooperate at Billings is in keeping with the traditions of the medical profession and the patriotic record of Hoosier physicians. In spite of the heavy demand upon their time, they respond to the call of need."

The plans for the new Veterans' Hospital call for one thousand beds, thus adding materially to the already-existing Veterans' Hospital on Cold Springs Road, Indianapolis, and the Billings Hospital. It is estimated by the American Legion that the available hospital bed space should be stepped up to the high figure of 1,500, and that even now there is a waiting list of 450, this being the number of veterans who should have hospital care, but who find no beds available. The total number of veterans in the area is estimated to number a half-million, thus it readily is seen that there must be an increase in the number of beds available.

This is not a matter of simple emergency, one that will "pass off" within a short time; rather we must look forward two or three decades, since it is almost certain that the load will but increase for that period of time.

The Indianapolis Medical Society is to be applauded for the business-like manner in which they approached the problem, and with the celerity of its action; there was no delay, no long-continued committee investigation—the group simply went to work on the problem and came up with a solution, just another instance of the manner in which Hoosier Medicine finds the answer to all problems confronting our group.

Because of the many mailing address changes incident to demobilization of those in the armed forces and subsequent relocation, we shall appreciate being informed promptly of any change of address.

CHILD HEALTH

We recently celebrated an occasion known as "Child Health Day," and we venture to state that few among the profession or the public gave it much thought. We have pretty nearly reached the point of saturation on "days" and "weeks" and "months" commemorating some event, or activity, or campaign, and we are inclined to take them in stride without too much of an upset in our regular routine.

American Medicine, however, can justifiably record a brilliant chapter in the phenomenal gains achieved in the control of death and disease in children.

The *Statistical Bulletin of the Metropolitan Life Insurance Company* advises that the death rate among children, aged one to fourteen, insured in their Industrial Department, dropped sharply and almost continuously in the past thirty-five years. A decrease of 76 per cent among white boys and 80 per cent among white girls, between 1911-1915 and 1941-1945, was accomplished during two world wars and a major economic depression.

During these periods the death rate from communicable diseases declined over 90 per cent. Deaths from diphtheria alone have decreased 97 per cent, and many large communities have not lost a single child by diphtheria for a series of years. The death rate from diarrhea and enteritis has declined 95 per cent. Where one child now dies from this cause, twenty died a little more than a generation ago.

Pneumonia and influenza still remain the ranking causes of death from diseases in children, but this rate is now only one-sixth of that prevailing thirty-five years ago. The trend has also been downward in the death rate from appendicitis.

While ranking high among the causes of death in children, the death rate from automobile accidents has been declining steadily during the past fifteen years, and fatalities from other types of accidents decreased nearly two-thirds during the periods studied.

The report concludes with this statement: "It is clear that giant strides have been made in protecting the life and health of American children, but public and private agencies in this field must continue their efforts, not only to maintain the gains achieved, but also to reduce sickness and death among children to a minimum. There are still many youngsters in our country who do not receive the full benefits of existing knowledge and facilities in medicine and public health. . . . With the proportion of children in our population decreasing, the future of the nation calls for sympathetic attention to the problems centering around their health and welfare."

Yes, "Child Health Day" should be *every* day.

OUR POSTWAR MEDICAL SCHOOLS

The editor of *The Journal of the American Medical Association* is much concerned over many of the postwar problems in our medical schools, and those conversant with existing conditions are agreed with him. The chiefest of these problems have to do with financial matters, since it seems certain that the income of most of our schools is being sharply reduced, with further restrictions in the offing.

The Selective Service System comes in for some justifiable criticism, in that it failed to provide for the training of scientists; most of us recall the clash that took place over these matters, the Service winning out, as usual. Then, too, the matter of salaries for full-time instructors is a most important phase of the problem. As was recently pointed out, "What chance do we have to secure a competent teacher in science when a full-time professor, after thirty years of service, may never reach a salary of $4,000.00?"

Most of our medical schools are not endowed schools; they depend on fees and on tax monies raised by the states concerned. It is certain that tuition fees will be much reduced in many of our schools, this for several reasons. One is that during the war the Army and Navy paid the fees of all out-state students, and these fees were higher than those charged resident students, the making for a reduction from that quarter. Another thing, since we have reverted to the three-quarters' system, rather than continuous operation, there will be a three-month lull in the matter of income.

Editor Fishbein is quite fearful lest the present dilemma will result in a lowering of medical education, a thing that would be most disastrous to all of us. It is to be hoped that something may be done not only to help our medical schools, financially, but to avert such a calamity as tampering with our present high standards of medical education.

And here in Indiana—as elsewhere—we have our own problems; as we view it, we need a lot of things, most of which will cost money. Presently we have a very fine setup in our Indiana University School of Medicine; our medical center equals that of most other schools, and is superior to many of them.

Our hospital facilities, right on the grounds of the medical center, are not exceeded by other teaching centers, and now we have a new hospital coming—the Veterans' Hospital. But with all this there are certain things to be done, things that need immediate action. First and of prime importance, we believe, is the transfer of the "First Year" from Bloomington to Indianapolis, and probably the addition of some medical men to the teaching staff of freshmen students.

But we feel that the big thing is to get the first-year students right up here on the medical campus; give them an opportunity to associate with other

upper classmen; give them an opportunity to associate with medical men who are in active practice right from the start, which will be much to their interest as well as to ours.

Such a change will, of course, cost money, money that will have to be appropriated by the Indiana General Assembly, which meets next January. It is not too early to begin plans for the presentation of a well-thought-out program for this session of the legislature. As we have stated on several occasions, Governor Gates has spoken out in high favor of increases in our medical education facilities. It is to be remembered that at the French Lick session, last November, he stressed the importance of "making better doctors," which meant a step-up in medical education. He also said that he was definitely aware that such measures would cost money, and strongly indicated that he would be glad to lend every effort to further the proposed moves.

Our Indiana University Medical School has a very high rating, but this rating can be made even better with the proposed changes. As we see it, it behooves each member of Hoosier Medicine to lend every effort to bring about the necessary changes, to put Indiana right at the top in the matter of medical education.

THE STATE OF THE NATION

Mary Jane Ward's emotional story of an insane woman's experience in a mental institution—"The Snake Pit"—is presented in condensed form in a recent issue of the *Reader's Digest*, and has elicited considerable discussion.

"Count Me Among the Living," a new novel by Ethol Sexton, traces a young woman's descent into madness. One reviewer has said, "Relentless as the march of fate, as horrible a revelation of the disintegration of the mind as any case history ever recorded in Vienna, written with baleful and stormy eloquence, the book has a bludgeoning power to command attention."

"Spellbound," a recent and excellently-produced movie, deals with a young woman psychiatrist's efforts to rouse a young man from amnesia, and much of its action also takes place in a mental institution.

"Shock," another movie, portrays the weird groping of a hysterical mind in a young wife and her endeavors to escape from an enforced stay in a sanitarium. It also seems to bear out an implication that in order to be a psychiatrist you have to be a little bit "nuts" yourself. Admittedly, if you can sit through the picture, you are.

Now *Life* magazine, in a recent issue, has come forth with a dozen or so pages of pictures and text devoted to an exposé of deplorable conditions in our mental hospitals.

This flood of literature and pictures dealing with mental illness might be considered a commentary upon the state of the nation.

"HOW NOW—BROWN COW?"

The Committee on Medical Information of the Allegheny County Medical Society of Pennsylvania is disturbed because of the apparent lack of interest, on the part of the medical profession, in providing informed public speakers to meet the aggressive challenge of the proponents of social legislation. They cite the fact that the number of physicians available for this work is very small because the doctors, as a whole, are either too busy to inform themselves on factual data about the subject, or they do not have the time to accept speaking engagements. We might add the further reason that doctors, as a class, are notoriously poor speakers. If they read a paper, which is a bad practice, too often they read it in a monotonous fashion with diction that must resemble the initial attempts of the proverbial Demosthenes with a mouthful of pebbles. Their stance, as they tee off on the opening line, is something you do not find in the books on good posture. Their gestures, if ever made, run the gamut from scratching the head; holding onto the back of a chair like a drowning sailor clutching a spar; buttoning and unbuttoning the coat; sinking the hands into the pants pockets, thus elevating the coat and exposing a posterior that is broad of beam and sometimes droopy; doodling with the watch chain, and a variety of hems and haws and mannerisms all of which detract from an otherwise worth-while message he may have to convey.

As a solution, the Allegheny society suggests that the American Medical Association provide an indoctrination course, at some central point, of three or four days, which will provide factual and other information useful to speakers who meet the public. They have found that in sending out speakers on "Socialized Medicine" the public and the cause of medicine has benefited greatly.

Well, a few years ago, when the first Wagner-Murray-Dingell Bill was presented, our state headquarters' office went to considerable trouble to work up a most excellent speakers' kit, containing all worth-while facts concerning the bill in 1-2-3 order. At the Secretaries' Conference that year they brought in a Professor of Public Speaking to show them how to do it. Everybody was enthusiastic. Whatever happened to it?

The suggestion for an indoctrination course is an excellent one. But, what seems to be a prime foundation is the generation among the doctors themselves of sufficient enthusiasm and willingness to prepare themselves to go out and meet the public and present the facts.

The day has long since passed, thank God, when one has to feel that he must be an orator and spout the thunder or mouth the cliches of the old-time spellbinders. Today the open-forum method of presentation of a topic offers the widest interest and has the most appeal. A thorough knowledge of the topic is therefore essential, but

the ambition to acquire this knowledge and to use it for the benefit of the public and for medicine is sadly lacking.

How can this enthusiasm and willingness be generated? We do not know the answer to that one. We do know that if a man is to buy a piece of property—a home, a stock, insurance or any other commodity affecting his economic status, he is apt, usually, to want to know what it's all about. Yet, he will allow subversive elements to lay the ground work for a complete subjection of his own business to governmental bureaucratic direction, and he will not take the time to find out what it's all about and carry this knowledge to the people who will be affected most of all.

Certainly a strong campaign for well-trained speakers in the medical profession is sorely needed. Better practice up on your diction. "How Now—Brown Cow?"

"OUR REHABILITATION"

Thus is the title of an editorial in the first issue of *The Journal of the Philippine Medical Association* to be published since the liberation of the Philippines, a message which America receives with open arms. Osler said that "Humanity has but three enemies; fever, famine, and war." The Philippines have had all three, but because of its fortitude the medical profession has stuck to its ideals and has conquered in its struggle. Now it emerges with renewed ardor, and we wish our Philippine colleagues Godspeed in their return to democracy.

"Four years ago the most destructive war in history ravaged the Philippines. A horde of ruthless invaders took possession of this country and immediately launched a systematic overall plan of imposing their ideologies on our people and of severing completely the cultural bond which bound us with the people of the United States. To escape from the sordid effect of the enemy's obnoxious propaganda and imposition, the Philippine Medical Association deftly maneuvered and parried with the enemy to be out of its clutches; it suspended in January, 1942, the publication of its official organ—*The Journal of the Philippine Medical Association*—to prevent its being used as a medium of propaganda.

"Now the people of the Philippines are liberated! The bond of friendship between the Filipinos and the Americans is now even stronger and their relations much closer and happier. As soon as the smoke of battle in Manila had cleared up and the American forces of liberation had completely put to rout the enemy and re-established our Commonwealth, the members of the Council of the Philippine Medical Association met and took stock of the tremendous losses of the medical profession in general, and of the association in particular. They discussed in detail the steps to be taken for the rehabilitation of the association and its component societies.

"As they deliberated, they could not but recall the heroic deeds of those members of the profession who died or were wounded while attending to the medical needs of the fighting forces as well as of the harassed civilians and of those engaged in the dangerous underground resistance movement; the pitiful conditions of the bulk of the masses during the latter part of the Japanese occupation—utterly destitute, maltreated, sick, starved, dying in great numbers due to malnutrition; the great wanton destruction and irreparable losses our medical institutions sustained—the deaths of some of our medical leaders, the destruction of hospitals, libraries, pathological museums, laboratories, and scientific records—all of which had set back the progress of medicine in our country.

"The tasks ahead are heavy and numerous and complicated. But the future is bright because the people's morale is high. With the essential aid of the Americans and with a determination to succeed, the Filipino people are rapidly rebuilding their country on the wreckage of the war. Assured of substantial help from its colleagues in America, the medical profession here faces the future bravely despite the dire aftermath of a bitterly destructive war. The medical societies in the provinces, despite difficulties that are almost insurmountable, are exerting herculean efforts to rehabilitate themselves, as can be gleaned in our section 'Society Activities' appearing elsewhere in this issue. The medical profession is deeply aware of its role in the reconstruction of our country; and, in playing this role, it has adopted as its slogan Sir William Osler's statement: 'The master word in medicine is work.' If we were able to survive those three dark years of extreme hardship and suffering, tribulation and despair, we can certainly also meet the challenge of the future.

"As this issue of THE JOURNAL comes off the press after a lapse of four painful years, it joins our government in expressing its profound gratitude to the Almighty and to the people of America for the liberation of the Philippines and for the blessings of democracy.

"This is the beginning of a new year. It is also the beginning of a new era. THE JOURNAL greets and extends its best wishes for a prosperous new year to those who have made this issue possible; the members of the Philippine Medical Association; the numerous medical entities, which used to send us their exchange publications before the war; the medical clinics abroad our forced isolation from which during the Japanese occupation deprived us of our great source of inspiration and new medical knowledge; and last, but not least, our advertisers who have given us substantial material help."

A.M.A. Session—San Francisco
July 1-5, 1946

ROLL OUT THE BARREL

It is interesting to note that housing shortages, coal strikes, black markets in meat, food and clothing, labor troubles of various kinds, increasing crime waves and numerous other deterrents to a normal productive economy have not dampened America's desire for amusement. Bars, night clubs, restaurants, theatres, race tracks, and baseball parks are jammed to capacity, everywhere. Liquor, such as it is, seems to be plentiful and consumption just as vigorous. Trying to get a ticket to a theatre is more difficult than trying to get a berth on a train, and just a little bit easier than obtaining a table in a night club. Money is so plentiful that it is being tossed around in the big cities like confetti by a sizeable group of pleasure-bent citizens whose tips to cab drivers exceed the fares, and who pay the doormen to tell them the correct time.

Unemployment, except where strikes in one industry close down other industries, is no problem and discharged service men are finding jobs or educational opportunities which are taking care of that phase of national recovery. Discharged service men, it is true, are not finding in all instances the kind of jobs they thought about while they were in the service, and consequently many of them are traveling about the country looking for opportunities where they can find a place to live.

Universities, expecting thousands of service men to swell student body ranks next fall, are using every means at their command to obtain housing facilities from trailers to barracks, and are meeting with only such success as can be measured by the difficulties in dealing with government agencies. The lives of the people are propelled at a jet propulsion rate, but speed, or even moderately quick action, is something that the government agencies have deleted from their rules.

Every town in the country, of any sizeable population, is jammed, packed with people. Hotel reservations are becoming a farce, many of the leading hotels not even bothering to "confirm on request" such reservations. Vacation time is approaching, and with the highways already well traveled, we hate to visualize the bumper to bumper condition ahead.

Where do all the people come from? Your guess is as good as ours. The milling mobs are throwing money around, and there seems to be no bottom to the barrel. The gay nineties and the roaring twenties were pikers compared with the howling forties.

Annual Session of the

Indiana State Medical Association

October 29, 30, and 31, 1946

Editorial Notes

Dr. Lowell S. Goin, past president of the California Medical Association, in discussing the "WMD" bill, now before a hearing committee in Congress, said, "In every nation where compulsory health insurance has been adopted, since it was first conceived in lock-step-loving Germany, politics has played havoc with the progress of medicine." A rather recent instance of this is New Zealand, where politics seem about to upset the Utopian ideas of conserving the health of the population.

The Convention number of THE JOURNAL will be wholly devoted to our new Section on General Practice. We feel that in creating this new Section the state association not only has recognized the largest percentage of its membership, but has "done itself proud" in the establishment of this new feature. Under the general direction of former President J. T. Oliphant, assisted by a hyperactive committee, rapid strides have been made for their debut at the coming Indianapolis session. Our prediction is that this Section will command a larger amount of attention and a larger attendance than any of the Sections.

"Last call for San Francisco!" Thus warns Ray Smith, our new executive secretary. Early indications are that the registration at this meeting will be record-making; it is the first regular session in the past five years, and hundreds of physicians are "rarin' " to go to an old-time A.M.A. meeting. Ray advises that transportation arrangements may be made through the headquarters' office, with every prospect of having a "Hoosier Special" of our own, with a several-days' post-convention tour of the West and Northwest. If you plan to go and have not made your train and hotel reservations, we would urge that you get in contact with Ray at once. He knows all the answers, and you will save much time by contacting him directly.

This issue of THE JOURNAL is devoted to "Venereal Disease Control," a problem accelerated by postwar conditions and in which the practitioner and public health officer must work together in those activities relating to their respective responsibilities, in order to safeguard the public health. Our public health officers have particularly felt the need for an issue of THE JOURNAL being devoted to this subject, and we are grateful to Dr. George W. Bowman, director of the Division of Venereal Disease Control, Indiana State Board of Health, for his assistance, and to the authors who have imparted of their skill and knowledge in order to make this number possible. Again our Indiana physicians have come to the front with abounding material, in an endeavor to do their part in solving this problem.

West Coast cities have for some months been quite concerned about the appearance of smallpox in their areas, and of late we have noted the appearance of this scourge in communities nearer home. It is declared that the present type of infection is quite different from the form familiar to most physicians, the virus appearing to be much "stronger" than what has heretofore been met. The death rate in the Pacific coastal area is much higher than in former years. The Indiana State Board of Health strongly recommends mass immunization. As Dr. Thurman B. Rice has said, "If it could be transmitted from the Orient to California, it could be carried from California to Indiana."

In this issue of THE JOURNAL we publish an address delivered before the Indianapolis Literary Club on April 21, 1924, by Dr. John H. Oliver, longtime head of the Department of Surgery in the Indiana Medical School. This is written in the typical "Oliver strain," which immediately will be recognized by the hundreds of Indiana physicians now living and who sat in his classes. Dr. Oliver's lectures were all delivered in the same vein, his sentences being filled with surprising phrases, all of which made each student alert to what was being said. He had a type of humor which we never have met elsewhere, before or since, and it is with much pleasure that we present this interestng article, sent in by William Niles Wishard, Jr., M.D.

It may be that some of our readers have not received every issue of THE JOURNAL at the usual time, one reason for this being the huge number of address changes that have to be made every month. Of course, many of these were due to war conditions, but we made every effort to get our magazine to our service members no matter where they were located.

In 1945 there was a total of 2,742 changes of address, and during the first four months of the current year the number reached 1,321; quite a lot of work involved in this single detail. Miss Reid, in the headquarters' office, maintains a membership file, with the last known address of each member; this list is being continually checked, that it may be kept as nearly up-to-date as possible. Over in THE JOURNAL office, Mrs. Rowlison is in charge of the mailing file, a job that requires a lot of time every week.

Another item that takes a great deal of time, especially early in the year, is the checking of delinquents—these names having to be taken out of the active file until such a time as their current dues have been paid. For example, in 1945 six hundred forty-four names were temporarily removed from these lists because dues had not been paid at the proper time.

We are reminded by Dr. Louis W. Spolyar that his committee on Industrial Health has recommended that each of our county societies have at least one meeting per year devoted to Industrial Medicine. This plan has been in effect in several counties already, and has met with much favor. In some instances these meetings have been held in various manufacturing plants, thereby adding to the general interest. To our mind there are few phases of present-day medical activities more important than the frank consideration of this somewhat new subject, "Industrial Health." As Doctor Spolyar has expressed it, "It has brought management and medicine together, and I'm quite certain will lead to a better understanding of the problem."

One method by which the medical profession can bring to the attention of the public the lay aspects of socialized medicine, information dealing with health matters, comments on prepayment insurance plans, and subjects dealing with control of tuberculosis, cancer, infantile paralysis, and venereal diseases would be for the county society to provide each hospital with a weekly supply of pamphlets dealing with these questions. The active support of each hospital should be secured in seeing that these pamphlets are passed out to convalescent patients and to their visitors—not a "Take One" method, but a personal distribution. Hospitals should be, and undoubtedly are, interested in promoting better relations with their patients, and should offer no opposition to conducting such a procedure. Medical societies, through their Public Relations Committees, should find this an excellent means of acquainting patients and their friends with the advances being made in medicine as well as the problems besetting it.

Comes the middle of May, when most of us are dusting off the long-delayed vacation plans which have been in moth balls for the past five years. And we find ourselves in a dilemma—what to do, and when and how to do it? It seems that just when post-war plans, concerning this and that, are settled, up looms a bigger one. Now it is the coal shortage, with the consequent shutdown that necessarily follows the shutting off of our supply of fuel. The railroads are for the time being taking off trains; they are combining other trains—instead of two or three "sections," they now have but one. Hotel facilities are being cut down; entertainment simply is out of the question so the lowly would-be traveler finds himself better off at home. Yesterday evening we noted in a Vox Pop section of a Chicago newspaper the plaint of a chap who had come to Chicago from the East, on a pleasure visit—his vacation. He found the streets darkened and the stores closed, save for four hours a day; theaters and movies shut down; "night life" just simply did not exist, so he decided to get back home if he could find transportation

President's Page

Complacency in an individual or group of individuals is bad in every application you care to make of the word, but it is especially bad when no effort is made by the ones concerned, even though information is easily obtainable on subjects that have to do with the welfare, both present and future, of every one in the medical practice.

As we travel over the state and come in contact with the members of our organization, we find amazing apathy towards some of the legislation that is thought to be very vicious, in that such legislation, if passed by our Congress, will shackle the freedom of the practice of medicine forever. I am sure that this regrettable situation is not due to ignorance, for all can read the progress of the hearings in the daily press and in the state and A.M.A. Journals. Every doctor in the nation should make himself a committee of one and give this information to every patient that comes under his care. Just remember that the national and local officers can not do all the combating of such evil propaganda without each and everyone's help. As we have stressed so many times, the practice of medicine, as we know it, is at the crossroads, one road leading to the right, the other to the left. Shall we take the one to the right for freedom, or shall we be compelled to take the one to the left that is full of shackles, in the form of political, bureaucratic, and lay-supervised medicine? To everyone of us, I say, "help, or take the consequences."

If you have followed the hearings in Congress and the testimony that has been given before the committee in the House of Representatives, I think that you will have to agree that the fight against us is growing strong, and unless our A.M.A. representatives give more and better testimony before said committee our cause will eventually be lost, and with it the hopes and prayers of a great portion of the general public. These citizens have high hope of our ability to help stop Socialism and Communism. Only a few days ago I heard a noted man make the statement that "the medical association is the last bulwark against such vicious types of government." That statement should make us redouble our efforts to hold and rekindle from time to time this kind of confidence.

There are other problems confronting us that must be solved during the organizational periods of such problems. Certain groups other than our own organization are pushing their pet projects up to a certain point without advice from the medical profession, and then call upon us for professional aid and assistance. These are unfair practices and doctors must be very careful as to how their assistance is given to such groups, from the standpoint of the public and the doctor alike. No special group should receive any more consideration than the general group, and if the disbursements of funds are to be made by these groups in consideration for the treatment of certain diseases, they should be used only for those who are unable to pay; and the individuals receiving such aid should have free choice of doctors. Here again mistakes can and will be made. But let all who participate in such programs keep their conscience clear by not infringing on the rights of others. The recognition of certain diseases in the early stages is the best medicine that can be practiced. But who can do this? The doctor, or who? If it is the doctor, then he should be given freedom in his management of such patients, and not have his hands tied by someone not in the know. Sometimes it is said that there are people who for publicity would sacrifice everything that is good in life. Such individuals should be taught the fallacy of such egotistical bigotry.

J. E. Farrell

ROUND THE RED LAMP

With Apologies to Dr. Doyle

By JOHN H. OLIVER, M.D.*

Read before the Indianapolis Literary Club on April 21, 1924; re-read before the Club on January 14, 1946 by William Niles Wishard, Jr., M.D., and before the Indianapolis Medical Society on February 5, 1946.

Ever since the beginning of medical practice in England, dating back to and having its origin, no doubt, during the era of the barber surgeons, a red lamp has been the insignia which has lured the ailing public into the toils of the practitioner of medicine. I have heard it intimated at times by malevolent individuals only, that doctors' offices should be marked in a similar manner in this country, the sinister meaning of which has always been resented by the profession. Some years ago, Dr. Conan Doyle, then an ordinary student and practitioner of medicine, before premature senile conditions and a love for ectoplastic art had affected his brain and led him into the realms of the unknowable, presented to the reading public a series of personal reminiscences and sketches, all of a professional or semi-professional nature, under the caption, "ROUND THE RED LAMP." In it he relates experiences and happenings of his student and early professional life and made of it a very readable volume. It has often occurred to me that I might sometime possibly interest the club in a similar collection of happenings from my own stores and weave them into a bit of fustian in which there was nothing to discuss, that might be soothing to tired minds as they rested from the consideration of more consequential things. It was not until the reading of this book called my attention to the fact that I discovered that the hallway leading to my office had been lighted by a lamp of a similar color for many years. In the early days, before many victims had been attracted by its seductive rubicund rays, an evening's contemplation was unexpectedly interrupted by the hurried advent of an excited messenger. "Come with me, Doctor, right away, please; there is a lady bleeding to death." To such a summons as this, no true physician ever hesitates to respond. It was old Guy de Chauliac, I believe, who in the early days of medicine wisely remarked that it took a brave man to look into the mouths of open blood vessels; and this sage expression came from the depths of personal experience which has been voiced by many a man and brother ever since. My anxious companion hurried me to the second floor of a nearby block and ushered me unceremoniously into a sumptuously-furnished apartment where I found the cause of the trouble reclining on a blood-bespattered bed surrounded by a number of excited females. The patient was the coolest individual in the room, perfectly calm and seemingly unconcerned; she appeared to be somewhere about thirty years of age, with fine eyes, intelligent face, and possessed of that indefinable something that denotes good breeding. She gave me as much of her history as I would allow between gulps of bright frothy blood, in a scarcely audible voice. This attack had come on suddenly a short time before. She had had a similar one several years earlier. She had lost the outer third of her left clavicle when a young girl, resultant from a compound fracture caused by a fall from her horse while fox hunting at her home in Virginia. A sister had died from hemorrhage of the lungs before her party gown could be removed, and her brother had gone the same way. Absolute quiet was then demanded and the fight was on; and a battle royal it was. For a time, in spite of all I could do, there seemed to be no checking of the flow of blood; and all the time the pulse was getting weaker and more rapid, but at last our sufferer dropped off to sleep and the danger was temporarily over. Now a new and interesting condition developed. The woman in authority, landlady, I supposed, motioned me out of the room and proceeded to inform me that the patient was tremendously wealthy, that she possessed a plantation in Virginia, the home place, a cattle ranch in western Kansas, and no end of stocks and bonds. She also told me the young lady had no relatives living and was engaged to a young member of the Marion County bar; that she had made no will, but had stated to her that in case of death, accidental or otherwise, she wished to make the young lawyer, aforesaid, her sole heir. The prospective legatee was out of the city. The landlady was firmly of the opinion that the patient would not live until morning. "What was to be done in the emergency," was the question propounded to me. I proposed that after a conference with the party of the first part when she awakened, if she so wished, we would send out for an attorney to draw the necessary instrument. She agreed to this shortly thereafter when I explained to her that we did not despair of her life, but were of the opinion that such a course would be advisable. Everything being satisfactory, I went to my office, promising to return in a short time, and walked away with visions of a glorious fee to remunerate me for my strenuous labors. Returning at the appointed time, I met an attorney, long an honored member of this club, then on the threshold of a prosperous career, who having finished drawing the will, was just leaving. His first question was,

* Deceased.

"Doctor, can she live until morning?" and then, "She is one of the most remarkable women that I have ever known. She has dictated to me the most satisfactory will I have ever written and that with my ear almost over her mouth, so faint were her whispered words." And then with some words not very complimentary to the legatee as a parting shot, he disappeared into the night.

And a hectic night it was, but the dawn found us still on the job. The patient was sleeping in response to weakness and narcotics, rousing to moments of incoherent whisperings with pinched face, blanched lips, and a rapid, thready pulse, wholly uncountable. But the hemorrhage had ceased and not a moment too soon. The first person to make a hurried entrance into my office on the following morning was a somewhat excited individual who took scant time to establish my identity and introduce himself. His first question was, "My God, Doctor! She can't get well, can she?" And so disgusted I was at the gleeful expression of his countenance and his seeming enthusiasm over his supposedly good fortune, that I told him forcibly that I thought she would, at least if it were in my power to save her. To make the long story short, the critical days dragged on and became weeks. Occasionally she had returns of the hemorrhage, but not of a serious nature; and all the time our young legal luminary was devotion itself. Flowers and fruits and nurses were furnished, and finally carriages when it appeared that the invalid was sufficiently recovered to take the air as our English friends put it. One morning several weeks later, he made a second hurried call to my office, and at this time his facial expression was very different from that of his first visit. He requested a private interview and informed me that he had become a bit suspicious of late and had written to the Clerk of the County in Virginia in which his friend was supposed to have a plantation. He had just received a letter in reply stating that no such plantation existed. He had then written a similar letter about the cattle ranch in Kansas and was anxiously awaiting results. A few days later, a very much subdued member of the bar called on me with the information that the cattle ranch did not exist, and that he had discovered the stocks and bonds were also a myth. With his head in his hands, he confided to me what I was easily able to believe that he had spent all the money he had, had borrowed all he could, and had gone heavily in debt. All the recompense he had been able to obtain was a proposal of marriage to be consummated immediately or dire results might be expected.

The interesting patient had sufficiently recovered to obtain a clerkship in the legislature then in session, and in view of this I bethought me that it was time to present a bill for my services, which I did. On the following day I received a visit from the lady, who in a very dignified manner expressed her astonishment at the smallness of the amount charged and hinted at wonderful things that were to happen in the near future. She asked, however, to be excused from immediate payment on account of temporary financial difficulties. The temporary difficulties seemed to continue and became chronic. On two or three later occasions I presented the account and always with the same result. I then turned the matter over to the attorney who had drawn the will, and who promised immediate results. After a visit or two, he admitted his defeat and told me that she had fairly talked him out of the room. As far as I know, the wedding was never solemnized and later she drifted farther afield. While I was resident at the City Hospital she used to meet me in the hallways when she was calling on friends in the wards, and always with stately dignity and with well-worded salutation greeted me. I was never able to learn anything as to her past history or antecedents. She was well-educated, evidently well-bred, and the coolest female I have ever met. She had deliberately planned the above fiasco when veritably in the jaws of death to insure care and attention while living and a decent burial following her expected demise.

I was summoned to the telephone one evening a short time ago and received the startling information that the lady at the other end of the line was admittedly unknown to me; that she had been suffering from a large goiter for some time and had hoped to be able to save up enough money to go to a good surgeon. She had been disappointed, however, and had about decided to come to me. I thought for a moment that the red light flickered a little and burned a shade redder.

I am also reminded that once upon a time I journeyed down to the goodly little city of Greensburg, and from there into the country a few miles to practice my vocation on an ailing old farmer, all upon a hot summer's day. Returning to the station, I entered a day coach of the Big Four Railroad, hot, somewhat disheveled, and bearing the varied impedimenta of my calling. I could see but one-half vacant seat, in the long and commodious car, and noted that the remaining half of that seat was occupied by what seemed at first glance to be an intelligent human being. First impressions are sometimes misleading. I asked as politely as I knew how, and in fact added a little extra polish to the interrogation, to be allowed to share his seat. The request was graciously granted and then the following conversation ensued:

Question by the seeming intelligent one, "What town is this?" "Greensburg." "How large is it?" "About six thousand." "Live here?" "No." . . . . "Where do you live?" "Indianapolis." . . . . "That so, I used to live there myself. What's your business?" "I am a doctor." . . . . "Veterinary?"

David Harum once sagely remarked that a certain amount of fleas were good for a dog; it made him forget that he was a dog.

One of our Indiana doctors residing in Muncie, a town from which nothing but good emanates, has recently sent forth a volume bearing the title, "The Humor and Pathos of Obstetrics." I have not examined the book and therefore am not aware as

to just what amount of humor he has been able to find in this primitive and all-important branch of engineering. Personally, I have been able to find pathos in plenty, but not much humor. There was one incident, however, that befell me while resident at our City Hospital which was not exactly humorous, but was at least unique. We always had then, and I presume that they have now, a plentiful lot of unfortunate babies, mostly entitled to the bar sinister, looking for homes. We could supply at a moment's notice almost any color or model of a baby that was called for. The hospital in those days was under the control of a board composed of members of the City Council, and the Board of Health, which is now all-powerful, had nothing to do with its management. I was called one day by a member of the Hospital Board, a highly-respectable physician of long practice, and asked if I had a brand new baby to give away. On being answered in the affirmative, he earnestly requested that I save it for him and that he would come out immediately. In a few minutes he made his promise good and entered an appearance accompanied by a comfortable female very well dressed, and who presented a front elevation that would indicate to the wayfaring individual that she was about to become a mother. The doctor requested a moment's private interview, after the fashion of doctors when momentous questions are to be discussed. This is the tale he told: his companion was the wife of a skilled mechanic; they were very respectable people and comfortably well off; he had known them and been their physician for several years. They had been married for about twelve years and had not been blessed with children, which was a great disappointment to both of them. Some months previous, the wife thought that she had noticed a change in her husband's attitude, which had alarmed her, and learning that babies could be had for the asking at the City Hospital, she adopted the following plan: She broke the joyous news to her despondent husband that she was at last in an interesting condition—and that without doubt, and that furthermore for fear of accidents she must forsake his bed and retire to another apartment. Great joy reigned in the household and all required concessions were cheerfully allowed. She then applied with timely regularity, padding, in concentric lamellae, over her abdomen, keeping time and size in perfect unison. The momentous hour had now arrived; the doctor and the nurse had been engaged; both gave their approval and entered into the spirit of the occasion; and now the baby was necessary. It was duly produced, forty-eight-hours old, fine and healthy, and the newly-made mother left in high glee. My friend, the doctor, called by phone on the day following and informed me that everything worked out to perfection. The husband, returning from the shop on call, found the infant in the crib, the mother in bed with the nurse in attendance, and everything to his untutored mind in regular order. Great happiness there was and continued to be, at least for several years thereafter, according to my informant, as long as the family was in his range of information. Was it a square deal? I have my doubts, and lay the soothing unction to my soul that I was acting under the direction of one of the members of my governing board. It resulted in a happy and contented household; gave a forlorn little chap a good home; and yet I have my doubts.

The disposal of unfortunate babies in those days was a somewhat serious question. I personally investigated every applicant, and many were refused, but when once a proper home, as far as I could determine, was secured, it was found best to keep no record of the transaction. Some years after leaving the hospital, there came into my consulting room one day, a fine upstanding young fellow who stood and looked at me with inquiring eyes for a moment or two, and then asked the rather unusual question, "Who am I?" On confession of my inability to make a diagnosis in his case without some laboratory investigation, as is now the vogue, he informed me that a day or two previously he had celebrated his twenty-first anniversary, and on that day his parents or at least those who up to that time he believed to be his parents and had loved and honored accordingly and with good reason therefor, had told him that having no children of their own they had applied to me at the City Hospital in Indianapolis for a baby, and he was that baby.

As far as love and affection were concerned he was their very own, and while it grieved them to disillusion him, yet for fear that later on he might acquire the truth, they thought it was their duty so to do; and further, they had no knowledge as to his real parentage and referred him to me for information. But the desired information was beyond me and he was compelled sorrowfully to go his way.

On another occasion, a well-dressed, and seemingly cultured lady visited me a dozen or more years after I had retired to private practice, and on entering my consulting room burst into tears and with outstretched arms cried out, "My God, Doctor! Where is my baby?" It was the old story, a college girl in a distant city who had loved not wisely but to well and had come to our City Hospital under an assumed name; had given her baby away; returned home; was in time honorably married; but without issue; and now Rachel-like, was mourning for that which could not be restored.

Driving along one of our crowded thoroughfares the other day, I almost brought my automobile back on its haunches, so suddenly did I stop at the sight of a well-remembered figure that I had not seen for years. Somewhat seedy and disreputable he looked as he slowly threaded his way along the sidewalk. His erstwhile flowing black mustache was now white, his shoulders a bit more stooped; and from out his heavy, expressionless face his beady, black eyes glanced furtively to the right and left from under his slouched hat. The very sight of him brought forth a flood of memories

of variegated hue, ranging from near tragedy to comedy. It was Doctor Billy, for many years Professor of Excavation and Extraction on the faculty of the Medical College of Indiana. A very important chair it was, by the way, and one he filled to perfection. He never failed to provide a plentiful supply of dissecting material and had a wonderful technique. I do not believe that the redoubtable Mr. Jerry Cruncher had anything on Bill. He was the most non-committal soul I ever knew; and in response to my inquiry as to what he was doing, he characteristically replied, "Nothing much"; and it was useless to interrogate him further. Bill's face was truly his fortune; he had passed through many a third-degree ordeal at the police station and had come out unscathed. When the great State of Indiana finally legalized dissection and provided a means of procuring material therefor without running the risk of getting shot or going to the penitentiary, Doctor Billy's occupation was gone. It is passing strange that so great an artist should have been known and appreciated by only three members of this Club; Dr. Ferguson, Dr. Hurty, and myself. Dr. Billy was a pupil of Old Turner, the last of the sextons at Greenlawn Cemetery; and Old Turner was a man of action with great presence of mind. It was said of him that when a famous, or on second thought, infamous, landlady of days gone by planted her foot in the soft earth at the head of a grave in which one of the unfortunate inmates of her establishment had just been buried, remarking that she intended to come out every day and see if the grave had been disturbed, Old Turner with rare prescience, promptly remarked, "Missy, that footprint of yours is too small; it will soon fill up; let me put my foot in. There, that will last some time, and you can see it easily." And so it did, after a few renewals.

Perhaps you will think it a far cry from grave-robbing to fee-splitting, and the similarity rests only in this: that the one in its day was a necessary evil, and the other today is an unnecessary evil, that has done much to break down the morale of the medical profession and has submitted the laity to a great deal of unnecessary surgery, performed frequently by incompetent operators. It permitted the tyro and the unskilled to buy business at the expense of the ignorant and unsuspecting. Grave-robbing was a traffic in dead bodies; fee-splitting is a traffic in living ones. This pernicious practice seems to have originated in Chicago some twenty-five or thirty years ago, when a surgeon, then in the beginning of his career in which he ultimately succeeded, was endeavoring to break his way into the clientele of the then-reigning favorite. Both were great surgeons, and both have passed on after having done much that will survive. It is said that as soon as our ambitious one had accomplished his purpose, he promptly abandoned the nefarious practice, and after that the very mention of the name had about the same effect on him as the word "wrinkles" had on Beau Brummell. Fee-splitting spread rapidly; it seemed to permeate the profession from center to circumference; it was a short-cut to prosperity. Many of the older and well-established men claimed that they had to fall in line to protect themselves while the general practitioner who referred the cases smiled complacently and gathered in much easy money. The general practitioner, aforesaid, had long complained of the surgeon getting the fees and of his getting nothing, and looked on the innovation as a step in the right direction. They soon found the man who would pay the biggest price, and then got out and hustled for business. Many border-line cases with shady diagnoses were operated by some surgeons when such proceedings were not necessary in order to save the faces of their friends who were sending them business. The conscience of the profession seems to have taken a big slump. It was at this time that the saving element came to the rescue and founded the American College of Surgeons through whose portals no fee-splitter can pass. The college has done and is doing a wonderful work, and fee-splitting is slowly but surely passing out. We still have them with us, good, bad, and indifferent; but the work of reformation goes steadily on; and I hope that in the near future no surgeon will be allowed to operate in our hospitals or belong to our societies who is guilty of this pernicious practice. I do not wish to convey the impression that all surgeons who do not belong to the American College are fee-splitters, far from it. It is safe, however, to infer that those who do belong are not guilty. It would also be far from my intention to accuse all general practitioners of being particeps criminis, but it is true that the practice spread like a pestilence and did not seem at all selective in its victims.

I presume that it is fair to admit that it is the unexpected which happens to persons in any walk of life, but I am inclined to believe that unlooked-for conditions and incidents are found to a greater extent in the daily life of the surgeon than in any other calling. He is trained for this and must be ready for any emergency at a moment's notice. Surprises must have no terrors for him. Answering a hurried call to a hospital a few years ago, I found a pale-faced, quiet figure on the table in the emergency room, stripped to the waist and covered with towels. The awe-struck appearance of the nurses and house doctors, something unusual under ordinary circumstances, elicited a questioning glance on my part. "Lift the towel, Doctor," was the answer; and then I saw what I have never seen before or since. The poor fellow had been caught between two cars moving in opposite directions and his chest had been so torn open that his heart was completely exposed to view, beating away regularly in its pericardial covering. Strange to say, he was thoroughly conscious although pulseless. It has been my custom for many years to call hurt railroad men Democrats. It is a euphonious appellation of honest Greek origin and supposed to be non-irritating. It is further applicable because fully seventy-five per cent of these men are so classified on the poll books. My first order to

the house surgeon was, "Hurry up, Doctor, and let's get some normal salt solution into this Democrat or he will get away from us." As I turned from the dreadful but fascinating view to assist in the procedure I had ordered, I heard a low chuckle and turning found the injured one laughing. Then in a low whisper, he said, "Say, Doc! How did you know I was a Democrat?" With these last words on earth, and with a smile on his lips, I saw his heart, poor, much-abused organ that it was, faithful to the end, shut up like a closed fist and open no more. Since that event I have been a bit careful about calling a badly-hurt man a Democrat.

It has been my good fortune to have been the recipient of a great many queer letters. They have certainly added variety which is supposed to be the spice necessary to well-ordered human existence. For several years in succession, I received well-written epistles from a poor woman, no address ever given, imploring me to send her the proper medicine or agent of any kind with which she might combat the evil machinations of her neighbors who were slowly but surely killing her by telepathy.

Another one, and one was enough, was received from a versatile crank living in a small town in the southern part of the state, who was openly looking for trouble. He premised the real essence of his letter by stating that the medical profession had unanimously concluded that the vermiform appendix was of no anatomic or physiologic significance and was only good to the surgeon from an economic standpoint. It was, in fact, a real meal ticket to the impecunious practitioner. He had discovered, however, that the vermiform appendix was a wonderful organ, the functions of which had been woefully overlooked, and that the human race was suffering greatly from its ruthless removal. He then gave an accurate description of the organ, its location, nerve and blood supply, preliminary to launching into a description of its real functions, which were as follows:

Being a tail-like affair, its length varying as to the size of the abdomen in which it was to functionate, it was intended to lash about among the viscera, stimulating the splanchnic nerves, and through them all the vital organs. But above all, to titillate and massage the undersurface of the liver, which was nature's way of overcoming the natural tendency of the human race to melancholia, and that no person who had had his appendix removed could expect to be happy and carefree again. He knew this to be true from his own personal experience, and that he intended to sue the surgeon who had thus ruined him, for malpractice, and besought my kindly assistance in so doing.

The following Macedonian cry for help contains hardly a single properly-spelled word, and yet it came from a doctor, practicing in a small town, not very far distant from that Athens of Indiana, classic Crawfordsville:

"Dr. John Oliver, M.D.
Indianapolis, Indiana

Dear Sir:

"I want your advice about a patient of mine that is very bad off and is the son of a rich citizen of this here county and having lots of influence. I hate to lose him and then he says he won't pay me if he don't get well or dies. I think he was took with consumption first as the top of his lung was powerful sore and he was confined two or three days before I could see him on account of my horse who has been very sick. I couldn't seem to do nothing for him, and now his stomach tube seems to be rotted off. Let me hear from you quick, and will you kindly send me a list of your prices because I want to be sure to get all that he owes me before he dies.

"Fraternally yours in trouble,
Dr. Blank, M.D.

"P.S. Please excuse penmanship and bad writing."

It is difficult to cull from the accumulated experiences of years the happenings and events that are apt to be of interest to the club. Many great discoveries and innovations that mark epochs have come to us since I first lighted the "red lamp" in my hallway. It was my good fortune to be the house surgeon on duty at our City Hospital on the service of the late Dr. John Chambers, one of the brightest young medical men that ever came to the City of Indianapolis, long since gone to an untimely grave when antiseptic surgery had its birth in that institution and in the city and state as far as I know. Our efforts were crude, very crude, as compared to the perfected technique of the present day; but one of our first cases, a thigh amputation, went home well at the end of two weeks, a result which we have never been able to improve on very much. Stimulated by the results following clean surgery, our surgeons were at that time just beginning with timorous fingers to invade the then-sacred precincts of the abdomen. How different from the present when the operating schedules of our combined hospitals will show a score or more of these operations in a single day. It was my good fortune to perform the first successful operation for gunshot wound of the intestines in our City Hospital, although the late Mr. W. P. Fishback had informed me in his kindly way that such a thing was impossible. Mr. Fishback was a very versatile man; this is no news to the older members of the club. There was nothing going on in our city, of any importance in his time, in which he was not interested. He had heard somehow of one of my abdominal gunshot cases of some importance that had resulted fatally, as they all had up to that time, and had stopped me on the street to tell me not to feel badly about it because the Lord never intended a man shot through the guts to get well. Unfortunately, he passed on just before my first successful case, following which

there were three others in close succession, all successful. It would have given me great pleasure, had he lived, to have reported them to him. In the train of antiseptic surgery came aseptic surgery, one simply a refinement of the other; and then the roentgen ray with its revolutionizing results, and serum therapy and radium, and many other things of less importance, and connected with each some interesting reminiscence all untellable for lack of time.

In his preface to his "RED LAMP STORIES," Dr. Doyle remarks that "a tale which may startle the reader out of his usual grooves of thought and shock him into seriousness plays the part of the alterative and tonic in medicine, bitter to the taste, but bracing in the result." With this text for an excuse, it is my firm intention to bring these ramblings to a close with just one more tale—just one—with the hope that this announcement will counteract the bitterness already engendered and act as a tonic which will brace you up and enable you to exist unto the end.

It was my good fortune some years ago, quite a number of them, in fact, to spend a few weeks recreation-bent with an old student and friend of mine practicing medicine in a rapidly-growing little city, a county seat, nestling in the foothills of the Rockies, in one of our then newly-born states. Shortly after my arrival and while lounging about the doctor's office, as I was wont to do between hunting and fishing expeditions, I had the pleasure of meeting with the judge of the County Court, a fine, upstanding chap whom the doctor informed me had already crossed the Biblical deadline without seeming injury in the transition. He was suffering from a rather painful malady, for the relief of which I was pleased to suggest a simple operation which gave him great relief and established me firmly in his good graces. There seemed to be but little known of his antecedents. As one citizen informed me, "He was here when everybody else came." The judge was quiet and reserved in the main, an excellent listener, but when stirred into active conversation, proved a fluent talker especially rich in the lore of pioneer days. He had taken Horace Greely's advice and had gone West when a young man; entered, proved up, and purchased valuable lands; had raised both cattle and sheep; and practiced law on the side when practice was to be obtained. He had been a justice of the peace in territorial days, and had been fully able to enforce the rules of his court, both by western and eastern methods. With the advent of the state courts, he had been elected judge, and judge he had been ever since. No one had ever thought of opposing him in his own party, and his party was paramount. He had married and reared a family. His wife had died a few years before; and his sons and daughters had married and dispersed, but he still continued to live in the fine, old country house in the edge of the city. I have never met up with mortal man who seemed so universally loved, honored, and esteemed. He had refused other preferment many times; might have been governor or congressman at will, if he had so desired; but he would have none of them. A judge he was, and a judge he had remained. Some months previous to my visit, a very popular young man was found murdered under circumstances that strongly implicated a rather ne'er-do-well, young chap, who had been or thought he had been a rival in a campaign for the good graces of one of the city's fair belles. The suspected murderer had, after a few days, been arrested; and the detective force of the city was able to weave about him such a web of circumstantial evidence, and circumstantial only, as to leave but little doubt in the public mind as to his guilt. The case came up for trial during my visit; and much to the surprise of everyone our judge seemed to lean strongly to the side of the defendant from the beginning. Objection by counsel for the defense to evidence introduced by the prosecution was sustained by the court if there was any plausible excuse therefor, so it was claimed. His instructions to the jury in which he discussed the reliability of circumstantial evidence and its value were strongly in keeping with his rulings during the whole course of the trial. The jury retired; returned a time or two for further instructions; and finally, after a long and tedious wait, agreed to disagree and were discharged. The failure of the jury to agree was attributed to the attitude of the judge, and raised a storm of indignation and disapproval that was voiced by press, pulpit, and populace. It was with difficulty that the judge's closest friends could find grace of heart to defend him, and our idol of yesterday was suddenly cast down from his pinnacle of public supremacy by a whirlwind of public condemnation. Doctors as a rule are not easily stampeded if imbued with the real medical diathesis, and my host never for a moment lost faith in his friend. An evening or two after the storm broke found us wending our way out to the judge's home to assure him of our unabated esteem and confidence, and comfort him with the spoken word. We found him sitting on his front porch facing the west alone with himself and his pipe.

It was one of those rare evenings in the early summer when all nature seems in accord and at rest. Out in the west the sublime, sweet evening star, embowered in faint tints of purple and gold, was slowly sinking to rest behind a far-distant line of snowcapped mountains that formed a silver ruffle of wondrous lace that bound the distant edge of the horizon. I never experience such an evening without recalling Lew Wallace's description in *Ben Hur* of the night of the nativity.

> "There was no wind; the atmosphere seemed never so pure; and the stillness was more than silence; it was a holy hush, a warning that heaven was stooping low to whisper some good thing to the listening earth."

Our friend received us with his accustomed kindly dignity. He seemed in no way disturbed

by the wealth of adverse criticism to which he had been subjected; in fact, he did not refer in any way to the doings of the last few days, but sat, slowly smoking his pipe and contemplating the starry grandeur of the western heavens which, with the dying afterglow, progressively grew in scintillating brilliance and beauty until the firmament seemed paved with a luminous mosaic of silver and gold.

I cannot, of course, remember exactly what he said. His words came slowly and much in the nature of a disjointed monologue, although I noted down as much as I could remember a little later and linked it together as well as I could. The immensity of the universe appalled him, not our comparatively little solar system, but the unnumbered others of which our finite minds could have no conception. He liked the sacred name Jehovah in preference to God because no one knew its origin or from what language it sprang. He liked to think that it had always existed and was likewise imperishable. It rang true with the great doings of the Old Bible; it fitted in with a concept that in a way he could grasp, a great entity comprising everything. The truths of the New Testament were hard for him to embrace. The teachings appealed to him. They were grand in their breadth and comprehension. But in spite of himself, the Christian religion at times seemed small and circumscribed and out of keeping with the magnitude of the universe. But when doubts came thick and fast, he fell back on a favorite thought from Browning,

"The sum of all is Yes, my doubt is great, my faith's still greater."

He seemed for a time to lapse into a profound revery, and finally rousing himself with an effort, began the following remarkable recital; speaking in a low voice with frequent pauses as if the events were painful to recall, and at times with apparent evidence of subdued emotion:

He was born in one of the larger New England towns. His father was a distinguished member of the bar and was descended from stern New England ancestors, possessing much of their hereditary austerity and straight-laced religious beliefs. He had no brothers or sisters and his mother had died in his early boyhood. The relationship between himself and his father was never very close, especially after he had become a bit wild and intractable. He was educated in one of the great universities and was graduated both in letters and the law. On returning home he entered his father's law office, but the tendencies of his youth had not been improved by his college education, and his escapades led to frequent altercations with his father which endangered his position in the office. His reputation in the community soon began to suffer and finally sank to about the same level as that of the defendant in the trial of the previous week. Now he was sure that there had been nothing vicious in his make-up. It was rather a full red-blooded desire for fun and excitement which occasionally, with the aid of alcoholic stimulants, outran the bounds of New England conventionality and reason. It was the same old tale, the intensely proper young business man and the young rake, both suitors for the same lady's hand in which the wild one had the seeming advantage, as is frequently the case. The father and mother of the young lady, however, would have none of him. The daughter was dutiful, and the sacrifice was made. On the occasion of his last visit, he found his successful rival in undisputed possession, so sure of his triumph that he soon left, pleading a pressing business engagement. After a brief and tearful interview, the vanquished rival took his final departure, sad and dejected. While walking homeward, he was startled by a cry for help coming from down a side street that he was about to cross, and turning, saw by the light from a coal-oil street lamp two men struggling some distance away. Running thither, he saw one of the men break loose from the other and strike his opponent down with a heavy weapon of some nature, then turn and run rapidly away. On reaching the fallen one and turning him over, he was horrified to find him dead. Evidently the skull had been crushed by the blow—and a moment later, to discover in the person of the murdered man his successful rival. He was carrying that evening a heavy, black-thorn stick which he dropped by the side of the murdered man as he stooped to examine him. Just as he was arising from his investigation several men ran up, and among them a policeman, who recognizing our wild young lawyer, promptly placed him under arrest as the murderer. Briefly, he was arraigned, tried for murder; convicted and sentenced to the penitentiary for life. The cane which he had dropped, now stained with blood, was introduced in evidence as the instrument of destruction. It was argued that he had left the home of his lady friend with premeditated murder in his heart; had followed his victim; and had struck him down in cold blood. Nothing but the reputation of his father, his youth and the straight-forward story he told on the witness stand, which the prosecutor could not shake, saved him from the gallows.

His father was early convinced of his guilt and pleaded with him to confess it; and when he flatly refused to do so, practically deserted him. It was useless for him to try to describe his state of mind as he departed to the penitentiary, manacled to the sheriff. All hope had deserted him, and the only problem left to solve was how to commit suicide. An hour or two after he started on his journey for what he supposed was a living death, and while the train was running rapidly through a somewhat lonesome bit of territory, there came a sudden crash, a sudden stoppage, a rending and grinding of everything about him, mingled with shouts and cries and pandemonium generally. He found himself practically hanging by his manacled wrist, still firmly attached to that of his convoy, half in and half out of the car which was resting partly on its side. He soon discovered that the sheriff was crushed to death over the arm of the

seat by the descending car roof which had caught all the passengers sitting next to the aisle, when the side of the car in which they were riding was torn out. The forward car had jumped the track and turned over. The rear car plunged on, and telescoping the two forward ones, had practically torn the whole train to pieces. He had been contemplating death as a blessing, and now found it all about him. Here he was, barring a few scratches and a contused wrist, unhurt. The crackle of flames soon began to add a new terror to the situation as the upturned stoves quickly set fire to the wooden cars. A desperate tug at the handcuffs quickly showed that nothing short of an amputation could free him without their removal. Luckily, he remembered that the sheriff's keys were in his right-hand coat pocket; and dragging himself up under the crushed body, still partly supported by the car seat, he was able to procure the coveted bunch and immediate freedom. Then he had an inspiration when he saw the arm of the man who had been sitting on the inside of the seat immediately in front of his dead companion, extending backward under the body. On his unresisting wrists he quickly snapped the steel bracelet. He had little difficulty in getting out of the wrecked coach and found a number of other passengers running hither and thither in a more or less dazed condition.

It was with difficulty that he resisted the temptation to be off immediately. As quickly as he could, he organized the uninjured ones into a relief squad and made such efforts as were possible to rescue those still living, but with little success as the flames by this time had gained such headway that the heat was unbearable. Fortunately, the engine had not left the track, but had broken loose from the train and now hurried to the nearest station to summon relief. He soon saw it returning loaded with men; and as there was now help aplenty, and but little to do as the wreck was well-nigh consumed, he decided to make his escape and found no difficulty in stealing away unobserved through a woodland that bordered the railroad track. There was another railroad a few miles distant, and towards this he bent his steps, intending to catch a train at the nearest station. Walking rapidly along, dazed with his new-found freedom, it suddenly dawned on him that he had no money. Sitting down to rest and think over the situation, he remembered a small package that he had in his pocket, which his father had given him the night before when he came to tell him goodbye. In it he found a Bible, and a letter urging him to confess, and as great good fortune would have it, one hundred dollars in bills. This money enabled him to make his way to New York where he read in the morning papers a full description of the horrible wreck and how, among other things, they had found the charred remains of the faithful sheriff still manacled to the prisoner. From New York he went to Chicago where he obtained employment for a time, and then westward. "Out here I prospered, and it is not necessary that I tell you of my prosperity.

"I have always intended to tell my story to some one, and I guess its about time I did. It has seemed to me at times that I must tell it, yet I never could tell why. I should have told my good wife, and so intended to do, but she passed on before I could gain sufficient courage. My friends, I have perfect confidence in your loyalty and discretion, and I am glad the ordeal is over. I shall not seek another election, I do not know," and he paused apparently in trouble, and then without another word he collapsed and fell over the left side of the chair in which he sat, and his pipe falling from his paralyzed hand, clattered on the floor. We sprang to his assistance and carried him into the house, summoning his housekeeper. There was no doubt as to the trouble. The purple face; the flapping cheeks; the widely-dilated pupil; the rackety, irregular respiration; the slow, full pulse; the sour smell of impending dissolution; and the line of foam forming on the lips told the tale. "Hemorrhage into the right ventricle," I involuntarily exclaimed, and "Thank God, a kindly big one!" was my friend's reverent reply.

VOICE OF MEDICINE

Lafayette, Indiana,
April 1, 1946.

Dr. E. M. Shanklin, Editor,
5141 Hohman Avenue,
Hammond, Indiana.

Dear Sir:

Aside from the several patent criticisms which might be made of Gutstein's article, "Percutaneous Tuberculin Therapy in Behavior Disorders of Children," appearing in the March Journal, a word of warning should be issued to those who are tempted to try this method of treatment. Anyone who has rubbed Tuberculin into fifteen or twenty scarifications of the skin of a child who has already been infected with the tubercle bacillus will never try it again. Certainly none of the thirty-two cases cited by the author were hypersensitive to Tuberculin or he could not say that "neither local, general, nor focal reactions have been observed. . . ."

Old Tuberulin in the *normal* human organism is inert or nearly so even in very large doses, whereas, in highly-sensitive individuals, reactions have been observed in doses as small as 1/1,000,000 of one milligram, the two procedures being totally different.

Yours truly,

Signed: J. W. STRAYER, M.D.

INDIANA BOARD OF GENERAL PRACTICE OF MEDICINE, INC.

The Incorporators and first Board of Directors of the Indiana Board of General Practice of Medicine, Inc., held a meeting on April 28, 1946, for the purpose of completing the organization of the board. Preceding issues of THE JOURNAL have presented the facts regarding the origin and development of a board to encourage achievements in the general practice of medicine in the same manner as boards of specialties have done in their fields.

At this meeting Articles of Incorporation and By-Laws were adopted. As soon as the typing and printing can be done, copies of the Articles and the By-Laws will be made available to all who are interested.

The following officers were elected:

President ..... Harry E. Klepinger, M.D.
Vice-president ..... J. T. Oliphant, M.D.
Secretary-treasurer ..... M. R. Lohman, M.D.

The Executive Committee of the corporation will consist of the President, Vice-President, and Secretary. There will be three other standing committees: Committee on Qualifications, Committee on Examinations, and Committee on Finance.

The following physicians were appointed to these committees:

Committee on Qualifications:
Clay Ball, M.D.
Robert W. Gehres, M.D.
Eugene Boggs, M.D.

Committee on Examinations:
C. G. Culbertson, M.D.
Harry E. Klepinger, M.D.
R. W. Lavengood, M.D.
James Baxter, Jr., M.D.
D. A. Gerrish, M.D.
F. A. Streck, M.D.
Orville M. Graves, M.D.

Committee on Finance:
J. E. Ferrell, M.D.
Eugene Boggs, M.D.
C. M. Sennett, M.D.
John Iddings, M.D.

While the founders membership is being completed, applications for regular membership will be received. The forms for application will be supplied upon request, addressed to Indiana Board of General Practice of Medicine, 1021 Hume Mansur Building, Indianapolis 4, Indiana. An application for membership will go to the Committee of Qualifications. It will determine whether or not the applicant is eligible to take the examination of the board. If it finds that he is eligible, the Committee on Examinations will give him an examination consisting of four parts, as follows:

Part I Review of case reports.
Part II. A written clinical examination.
Part III. An oral clinical test.
Part IV. A demonstration of ability at bedside and in laboratory.

If the applicant passes the examination he will then be admitted to membership on the board, and will receive a certificate showing that he has met the requirements for membership, and that the board therefore admits him and awards to him the honor of "Diplomate of the Indiana Board of General Practice."

The enrollment of founder members is proceeding. A great deal of interest has been manifested. The committee approved by the medical association to initiate and organize this board is much encouraged by the favorable reception of the idea shown in the response of physicians throughout the state.

The committee, which now constitutes the incorporators and first members of the Board of Directors, is considering plans through which post-graduate work of a thoroughly practical nature may be made available to diplomates of the board. It is hoped to extend this opportunity for post-graduate work to other general practitioners throughout the state. An effort will be made to organize the post-graduate work in such a manner as to make it possible for it to be taken without seriously interfering with practice.

The more the physicians who are organizing this board have studied and worked on plans for it, the more they are convinced that the purposes for which it is being organized will be accomplished. Those purposes are stated in the Articles of Incorporation, as follows:

"To encourage the study, improve the practice, elevate the standards, and advance the cause of the general practice of medicine by:

"(1) Creating incentive and inducement, through the prestige and distinction that accompanies recognition of achievement, to physicians to attain proficiency in the general practice of medicine;

"(2) Developing a sense of unity and cooperation among those engaged in the general practice of medicine;

"(3) Improving the educational opportunities of general practitioners;

"(4) Determining, by examination and otherwise, the competency of general practitioners who desire special recognition;

"(5) Granting certificates of membership and awards of an appropriate honor, showing membership in this board, on proof of qualifications to be established by the By-Laws of the board;

"(6) Making the general practice of medicine a field in which the highest abilities may find opportunities as attractive as in any field into

which physicians may enter with the expectation of making work in that field the career of their entire lives—

"all to the end that the general practice of medicine may come to occupy the position which the interest of providing the most adequate medical care for the public requires that it should occupy."

OUR OWN MEDICAL PLAN

WALTER URBAN KENNEDY, M.D.*

NEW CASTLE

In the preceding issue some of the reasons for formation of our mutual insurance company were set forth. Since then we have had opportunity to attend the sessions of the Committee on Education of the United States Senate, which is now considering the Wagner-Murray Bill. The committee chairman, Senator Murray is, of course, so much in favor of his bill that the proceedings of the committee are distinctly influenced by the constantly-evidenced bias of the chairman. The advocates, who are numerous and in many instances quite well-known to the public, reiterate the usual pleas of concern for the health of the public, making statements without actual knowledge of need or of the end results of their proposals. Stress is laid upon the need of more rather than better medical care, and the assumption is cheerfully made that to cheapen and make freely-accessible all forms of medical care will forthwith prove a panacea for all human ailments. They insist that the draft-rejection figures point to an alarming physical degeneration which urgently requires provision by the government of free medical care. No effort is made by these proponents to break down the draft figures or even consult the actual tables which clearly set forth the very large number of rejections for congenital deformities, such as club foot, loss of legs or hands, spinal variations, et cetera; they disregard the congenital visual defects and quite overlook the evident fact that more medical care could not affect these elements, and they similarly overlook the impact on disability of inadequate food, housing, and sanitary defects, as well as the very considerable number of abnormal or subnormal brain and nervous system defects for which no medical cure is presently known. They calmly disregard the experience of other nations and refuse to believe that governmental rules and regulations can interfere with adequate care of the individual. Medical care is looked upon as a mass-production matter and the individual as an insensate cog to whom it is only necessary to give a predetermined fragment of care for the amelioration of all human disorders.

But the point that interests us is that there is wide publicity of these illy-considered views, while the practical aspects are disregarded. Throughout the discussion there was constant query as to whether the doctors thought they might succeed by voluntary methods. As the proceedings continued it became evident that such success was our only hope of preventing the regimentation inherent in the Wagner Bill. The proposers indignantly object to the term "regimentation" and "socialization," but even a casual reading of the bill gives the lie to the denials.

It is a matter of constant wonderment to me how any doctor can fail to secure a copy of this bill and read it carefully. It directly and with the gravest importance affects him, his family, and his future. And it now seems more apparent than ever that the profession must, in every state, adopt medical care plans, and as quickly as feasible widen their application to meet all demands, required or demanded.

We are starting under the handicap of dangerous delay and must try by generous and unlimited support of our proposed plans to make adequate answer to the visionary and impractical demands on us.

Following authorization by the House of Delegates to form and activate our Mutual Medical Care, Inc., an organization was formed by a group of incorporators, named by the President of the State Association, who applied for a charter under the Indiana insurance laws and, upon the granting of this, set up the full organization by electing the President and other officers, setting up a Board of Directors, made up of the incorporators, with desirable additions, and began formulating the necessary contracts and the necessary documents required in sales, collections and administration. A contract was made with the Indiana Blue Cross to take over sales and collections, it being the plan to require each subscriber to carry a hospitalization contract before selling a medical care policy. After collection of monthly payments by the subscriber, the resultant funds become available to the medical plan for payment of the indemnities arising. The rate was set at a saleable level and the indemnity tailored to the actuarial requirements of the monthly rates. This gave us a somewhat lower indemnity table than desired, but there is a sales resistance which could not be met if over a definite cost level, and since payments from the funds cannot be made until the payments are collected, it is necessary to adjust the fee table on a realistic basis. We think it necessary to have such spread between intake and outgo as will adequately cover the expected early high administra-

* President, Mutual Medical Care, Inc.

tive percentage and set up adequate reserves to meet the expected early losses and provide against unforeseen high claim peaks. When the income is sufficiently stabilized and the administrative and reserve costs are accurately determined, the indemnity rates paid will be increased, there being two general aims, first of lowering the sales cost, and second, increase of benefits. We feel that our early limits of coverage are entirely inadequate to meet the ultimate aims and intend satisfying the need of coverage for all illnesses, both medical and surgical, as soon as our experience and funds permit us so to do. We think that permanent retention of our present coverage limits would defeat the real purposes of the movement, and that we may only avoid compulsory governmental insurance by full coverage eventually. We will also set up a special reserve intended to give extended insurance to provide for the need of subscribers temporarily unable to pay because of disability or lack of work.

An immediate campaign was begun to secure the necessary capital funds. It was thought that $65,000 would provide an adequate basis, but the addition of some medical care in addition to the proposed setup made desirable a greater capital base. Our adopted policy will be to provide indemnity benefits for all forms of surgery done in the hospital, for fractures, common minor operations done outside the hospital, obstetrics either in the home or the hospital, and for a twenty-one-day purely medical benefit while in the hospital. In addition, to meet a persistent and loudly-expressed complaint of inability to carry the policy during disability or lack of work, we will incorporate an extended time provision by which a policy may remain in effect for a limited period without premium payment. This will be done by a special reserve charge since there are no paid-up values in the policy. We also require that the policy be sold with the Blue Cross policy, since it would be of little value without hospitalization provision. The group method will be required in the beginning with provision for individual carriage after leaving the group. Since the group method gives a better selection and lessens costs of solicitation and collection, it will be used in the initial phases. As we develop experience and accumulate reserve funds, we will lower the group number requirements and attempt to spread them outside of industry, and eventually offer individual policies. So, also, do we look forward to increasing the coverage in purely medical cases, as our experience and funds permit. To have lesser objectives would make the whole program futile. We must not lose sight of the cost element, because over a given amount of cost, sales resistance mounts, and since our principal objective is the enrollment of low income groups, we will begin with a monthly charge of $1.00 for individuals and $2.25 for families. We provide for payment of the indemnity by a check payable to both the doctor and the patient. We place above all other considerations the question of safety and solidity, knowing what a blow a failure of adequate financial provision might be to the profesion as well as the insured. It may be noted here that there is a curious indifference of doctors to the only present hope they have for protection against socialized medicine. It would seem that men would be anxious to contribute to a movement by which they derive so much reward in attempting to preserve the things they believe in and live by. But the response is limited to a small percentage of the men concerned. And even among them, the responses are, in amount, much below their ability. In general, the profession is strongly in favor of the proposed methods, but exhibit a strong tendency to "let George do it." We are attempting by repeated circular letters and society addresses to change that attitude.

Finally, with a completed organization, with attractive policies, with a plan at its lowest possible cost, we are embarking upon the adventure of serving the public as doctors always have. And with the hope that our endeavors in Indiana, coordinated with similar efforts in all the states, will free the public and the profession of the real menace to the common good, inherent in all plans for compulsory medical care. The current Wagner Bill no longer pretends to limit its provisions to low income groups, but takes in everyone except indigents. So we, through our indemnity plans, are ready to care for every income level. We shall have need of the wholehearted support of the medical profession and the thinking public.

SCIENTIFIC EXHIBIT

A scientific exhibit will be held in conjunction with the annual session of the Indiana State Medical Association, in Indianapolis, on October 29 and 30. If you have an exhibit which would be of interest, the Committee on Scientific Exhibit would appreciate receiving your application for space. Please send your application to

C. G. CULBERTSON, M.D., *Chairman*,
Committee on Scientific Exhibit,
1021 Hume Mansur Building,
Indianapolis 4, Indiana.

FROM KARACHI TO MESHED BY JEEP

IVAN WINFIELD SCOTT, M.D.

INDIANAPOLIS

(Doctor Scott probably had one of the most interesting and unique experiences during World War II, and we have therefore asked him to share it with us. Get out your World Map and follow the route of his adventure, and we can assure you that you will have an interesting journey. THE JOURNAL invites others to contribute similar experiences.)

The incidents to be related here have been called to mind by a diary which I kept of an overland journey from India to the Russian border, made in the fall of 1942. At this time the amount of supplies reaching Murmansk by the north Atlantic route was being seriously reduced by ship sinkings. It was contemplated establishing an overland route from Karachi, India, to Meshed, Iran, for the delivery of American war goods to Russia. Although people have lived in this part of the world since the beginning of time, and several conquering armies have in history—including Alexander the Great—marched across it, there were no accurate maps or knowledge of routes through this area. It was necessary to send a reconnaissance party over the route to see if it would be possible for Army vehicles to traverse it.

I was lucky enough to be selected as the medical officer to accompany the party. The party consisted of two Army engineers, two ordnance officers, two civilians as United States Transportation Advisers, and myself. At Quetta, India, we picked up a Captain Rassaq, a Mohammedan of the British Army Intelligence, and his bearer, as well as a lorry with two Sikh drivers, to carry our rations and supplies. We could not go by the most direct route which would have taken us across Afghanistan, because of being denied entry into that country. Hence, we had to go around by way of Baluchistan. Captain Rassaq, who was a perfect gentleman and officer, was our guide and interpreter. Being the first American Army personnel to visit Quetta, the headquarters of the Northwest Army of India, we were wined and dined and treated as visiting royalty. We were given the best information available as to the country into which we were going, and advice as to the availability of water and persons to contact. Quetta is nestled in mountains about five thousand feet high and looks as much like a small American town as any seen in India. Its buildings are almost all new, being built since the city was destroyed by a severe earthquake some time in the 1930's. We entered the plains of Baluchistan through Lukh Pass, which is as impressive to see but not so well known to the world as the Khyber Pass. Aside from the British lorry we had a peep and a jeep. We had no enlisted men with us, and consequently cooked our own meals, made our own camp, and did all of our driving by turns. The roads, where they existed at all, were either dirt roads, or made from sand and crushed volcanic rock. One long stretch was simply a huge plain of sand and dirt baked as hard and smooth as a billiard table, and no road crossed it. Here we saw numerous mirages of water, boats, and docks—and we were all perfectly sober. We would occasionally drive all day and not see a sign of vegetation. Now and then we would meet or pass a camel caravan, but no other vehicles. It was along this route that Alexander the Great passed on his way to India, and the headdress of his warriors can still be seen in that worn by the Baluchs along this route. We turned north at Zahidan, the first town we reached in Iran. Zahidan means, "meeting place of the holy," but until fairly recently it had been known as Duzdab, or, "watering hole for thieves."

The poverty of the people in these Iranian villages is unbelievable. Their clothes were in tatters, and they all appeared poorly fed. Blindness in one or both eyes is common, either, I



A camel caravan loaded with cotton along the road just north of Hadcai on early morning of October 23, 1942.



These bullock carts are primitive, showing wheels made in three pieces, which were made in Biblical times.



Shrine of the 8th Iman, Meshed (November, 1942).

suppose, from trachoma or gonorrheal ophthalmia. Their diet consists mostly of japoti, a thin bread made of coarsely-ground flour and rolled into sheets about fifteen inches wide and a yard long.

At Birjand we stayed overnight and had the opportunity of visiting some places where Persian rugs are made. The rooms were dark to the point where it took some time to adjust our eyes from the outside light. The master sings in a sing-song chant the colors and number of each yarn to be used, and is answered by the weavers as they comply, in a sing-song manner. The weavers range in age from six years to old age, which in Persia is about forty-five years. Their hands work so fast, tying knots and cutting, that it is almost impossible to follow them with the eyes. At another spot on our journey through Iran we saw women grinding grain, and were told that they were paid in opium.

About two weeks from the time we started on this journey we came in sight of our destination, Meshed. It is a Mohammedan holy city, the eighth prophet of Mohammed being buried there. When the city came into view on the plain with its gold-domed shrine dominating it, we were halted by a Russian sentry who would not let us pass. Russia had occupied northern Iran, and the city lay in this territory. Since none of us spoke Russian, we could not get across to the sentry that we had come all this distance just to survey a route to bring them supplies. Finally, a peasant who spoke Russian and Persian interpreted to Captain Rassaq, who then translated the Persian into English for us. We were finally allowed to proceed, but had to enter the city by a back gate because we were not allowed to drive past the Russian airdrome.

The city was typically eastern, with narrow cobblestone streets and a fairly intact wall around it. Long strings of shaggy, belled camels entered and left all hours of the day and night, carrying merchandise and grain. It was our great fortune to find that we were expected at the American Mission Hospital, run by two well-trained, earnest doctors and a minister. Their wives were with them, and they had spent practically their entire lives in this out-of-the-way spot in the world. Their homes and the hospital were in a compound within the filthy city, but they had transformed it into a small portion of the U. S. A. It was a real pleasure to us to enjoy the boundless hospitality of these remarkable people, who, I believe, enjoyed seeing fellow Americans, too. There was one American nurse in this group who trained and supervised the Iranian nurses who worked in the hospital.

One of the first things I did was to see the hospital and the patients. Most types of surgery and all types of medical cases were to be found. I was particularly impressed by one case. The three-year-old son of an Afghan chieftain had recently had a cystostomy for removal of a bladder calculus, and was convalescing nicely. In his room was a table spread with native delicacies. I was urged to take some by the father, and did so only because the American surgeon told me that I would offend him if I refused. I selected some sugar-coated pistachios, which seemed to please everyone, including two of the chief's veiled wives who stood at a respectful distance behind him.

The surgeon told me later that the chieftain had had the boy treated by an Afghan doctor, who by some incantation and tribal medicine claimed to have cured the child of his malady. When the chieftain was not satisfied, and brought the child to the mission hospital where the calculus was found, he swore vengeance on the Afghan doctor. He promised to burn the doctor's father, which seems to be the way of visiting punishment on another in Afghanistan.

Later I sat with the surgeon while he conducted an out-patient clinic in several languages and dialects. In this period I saw patients in various stages of trachoma, leprosy, and many with diseases common in our own clinics. For those who could pay, a small fee was charged, but most of them were treated free. For the most part the patients were visibly grateful for the care they received.

On another day we were shown around the Shahriza Hospital, a Mohammedan institution maintained by proceeds from the shrine located in the city. It was a modern, well-equipped hospital woefully understaffed. There were three or four European, Jewish refugee doctors, but the remainder were Iranian men trained at the American University at Beirut. The equipment, such as x-ray, laboratory, and surgical instruments, was mostly of German and French make. Part of the hospital had been taken over by the Russian Army for soldier patients from the Stalingrad front, as the Battle of Stalingrad was then in progress. This area of the hospital was surrounded by an armed patrol, and no contact could be made with the patients.

Probably one of the highlights of the entire journey was the visit to the gold-domed shrine. It covered about two city blocks and was about seven hundred years old. It is one of the holy

places to which faithful Mohammedans make pilgrimages. The aged grandeur of the interior taxes my poor powers of description. The walls and ceilings are all carved and contain mosaic tile designs. The print from pages of the Koran cover the walls. In the various lofty rooms enormous crystal chandeliers hang from the ceilings. Throughout the centuries the faithful have given large oriental rugs to the shrine, and these have become so numerous that there are several layers on the floors. Large silver doors separate the various chambers. Through all these chambers numerous pigeons fly unmolested. Beneath the dome is the shrine proper, with the jewel-encrusted sarcophagus of the prophet, which is dazzling. Everywhere within the shrine were kneeling, praying, Mohammedans. We made the trip throughout the shrine barefooted, as no wearing of shoes is permitted inside.

Our business finished in Meshed, we departed after some more difficulty with the Russian sentry. The second day on our return journey we blew out our last spare tire, and at this time we were one hundred and fifty miles from the nearest telegraph line, and six hundred miles from the closest railway. We drew lots to see who should remain with the vehicle without tires, and the rest of us piled into the lorry and peep enroute to the village with telegraph service. We wired Karachi to fly extra tires to us, to be dropped by parachute. After four days' waiting, a cargo plane appeared in the skies, circled, dropped four tires, and flew away. These villagers had never seen a plane before, and were completely awed; and a herd of camels grazing in the valley where the tires were dropped took to the hills, and probably have not been caught yet.

While waiting for these tires word spread throughout the village that an American doctor was among them, and the sick began—at first timidly—to come for medical aid. By the fourth day the number had reached sizeable proportions, and although I could do little for them, I did examine many, who seemed grateful for even this small attention. The language difficulty was a great handicap in my feeble attempt to examine and treat them.

Our vehicles again in running order, we resumed our travel. By the end of our journey we had been gone almost five weeks, and had traveled approximately three thousand seven hundred miles, all by *peep* and *jeep*. (If anyone wants an opinion as to the riding qualities of these vehicles, I will be glad to give mine for what it is worth.)

REACTION OF UNIVERSITY STUDENTS TO THE WAGNER-MURRAY-DINGELL BILL

In an editorial entitled, "State Medicine Is Not the Answer," found in the *Indianapolis Star* of April 14, attention is called to two church groups who had appeared at a Senate Committee hearing favoring the Wagner-Murray-Dingell Bill.

It will be interesting to members of the medical profession of Indiana to know the reaction of certain groups of students here at Indiana University to this bill.

Recently there was a joint meeting of two large groups of students, students of the Wesley Foundation (Methodist), and of the Hillel Foundation (Jewish), at the home of the latter, with Rabbi Jospe presiding, and Rev. Forbes of the Wesley Foundation conducting a brief religious service. Following this service there was a panel discussion of the question, "Do We Want National Health Insurance?"

A member of the Department of Sociology had been asked to take the affirmative, and Dr. Neal Baxter had been asked to take the negative. Dr. Baxter had invited me to go along.

Dr. Baxter made the point that the question was double-barreled. If we ask the question, "Do We Want Health Insurance?" the answer is "Yes!" But if we ask the question, "Do We Want Health Insurance under Federal Control?" the answer is emphatically "No!" Dr. Baxter then proceeded with an analysis of the Wagner-Murray-Dingell Bill with its implications. He told why we should not have National Health Insurance, mentioning among other things its expense under federal administration, the building up of the already-dangerous Bureaucracy, and the fact that Health Insurance was being organized here in Indiana, on a non-profit basis and under medical control.

I was delighted with the way in which these two student groups came to Dr. Baxter's support.

I cannot say that this reaction would be the same in student groups of all colleges, but I am sure it is the reaction on every campus where, as at Indiana, the thousands of the student body have an annual demonstration of:

1. The severe competition to secure admission to a freshman medical class, and
2. The intensity of application necessary to hold one's place in class when once accepted.

Observations of this character engender in the minds of thousands of fellow students in other fields a high regard for the medical student and the medical profession, and constitute a backlog of good will and straight thinking at a time when do-gooders appear before a Senate Committee, favoring an ill-advised Wagner-Murray-Dingell Bill.

BURTON D. MYERS, *Dean Emeritus*,
Indiana University School of Medicine.

Military News

After five years of service with the Army, Dr. Harvey E. White has opened an office for the practice of medicine in Farmland.

Announcement of his return from military service and resumption of his practice has been made by Dr. Robert H. Wiseheart, of Lebanon.

Captain John M. Young, of Cumberland, expects to resume the practice of urology in Indianapolis within the near future, following his recent release from the service.

Major Welbon D. Britton, of Beech Grove, has returned home after three years in service. Overseas for two years, Doctor Britton served in both the European and Pacific Theatres.

Captain Charles L. Herrick, of Akron, has resumed his practice there, after serving for the past forty-four months in the Army Medical Corps, eighteen months of which were spent overseas.

Major Alfred J. Dainko, of Whiting, has returned to his practice of medicine after serving for four years in the Army Air Force. Doctor Dainko served at most of the Army air base hospitals in the United States, and received his discharge at Stockton Field, Stockton, California.

After four years' service in the United States Army, Captain Richard W. Terrill has resumed his practice in Fort Wayne. Doctor Terrill served for six and one-half months in the European Theatre of Operations with the 126th Evacuation Hospital.

Major Harold F. Zwick, of Decatur, has reopened his office there. Doctor Zwick was with the Army for five years, and spent most of his time in the service overseas in the China-Burma-India Theatre.

Dr. Arthur R. Savage, of Fort Wayne, was recently appointed deputy coroner, a position he held prior to his entrance into military service. He was a captain in the Medical Corps, and served in the European Theatre of War.

Discharged after four years of service in the Army, Lieutenant Colonel Robert D. Fry, of Indianapolis, has returned to practice in the Hume-Mansur Building. Doctor Fry was chief of surgery in station and general hospitals, both in this country and overseas. He served in Europe for a year.

On May first Dr. Frederick A. Resch, of Bluffton, entered the Army, as a first lieutenant in the Medical Corps.

Major Howard S. Williams, Jr., of Indianapolis, is now practicing internal medicine there since his separation from the service. Doctor Williams was in the Army for more than five years, and spent thirty-two months in India and China.

Recently returned from the European Theatre of War, Captain Leon Kressler, of Rensselaer, has resumed the practice of medicine and surgery in Rensselaer, which was interrupted by his military service.

Lieutenant Colonel Ben J. Siebenthal, formerly of Bloomington, has gone to South Bend to begin the practice of medicine. Doctor Siebenthal went into the Army in July, 1941. He served in the Burma-India Theatre, and was released from the service in December.

Lieutenant Wendell A. Prough, of Indianapolis, who has been in the Central Pacific, has been transferred to the Naval Air Station Dispensary, at Corpus Christi, Texas, as a medical officer. He has been in the service since 1942.

Major Edgar L. Engel, of Evansville, has resumed his practice after three and one-half years of Army duty. Doctor Engel served as chief of the Obstetrics and Gynecology Section of the O'Reilly General Hospital, in Springfield, Missouri, where his patients were largely civilian dependents.

After more than three years of service with an Army Troop Carrier Group and Surgical Hospital Unit in the Southwest Pacific, Captain Max C. Salb has returned to private medical practice in Indianapolis. During his tour of duty Doctor Salb was awarded six combat stars and four service ribbons.

Major Dan L. Urschel, formerly of Mentone, was promoted to the rank of major in March, and shortly thereafter was assigned to duty as chief of the Out-patient Service at the Walter Reed General Hospital, in Washington, where he has been since January. Doctor Urschel was formerly assistant chief of Medical Service at the Battey General Hospital, in Rome, Georgia. He expects to be released from active duty next fall.

Following three years in service, two and one-half of which were spent in Europe, Major George D. Davis, of Indianapolis, began a two-year Fellowship in Radiology at the Mayo Clinic, in Rochester, Minnesota, on April first.

Dr. Aaron L. Arnold, of Indianapolis, who held the rank of major, and who served in New Guinea with the 49th General Hospital as chief of Communicable Disease Section, has returned to private service. He was in the Army for three and one-half years.

Wounded and taken a prisoner of war by the Germans, while serving as a member of the 101st Airborne Division, Dr. Alvin F. Cohn, of Clinton, has been released from service and has begun the practice of medicine there. Doctor Cohn entered the armed services in 1942, and was a prisoner of war for four months before being released in October, 1945.

After completing some refresher courses at the Indiana University School of Medicine, Captain C. G. Kern, of Lebanon, plans to resume his medical practice there in the near future. Doctor Kern is on terminal leave from the Medical Corps of the Army Air Corps, with which he spent three years and nine months.

Information has reached THE JOURNAL office to the effect that Lieutenant Commander J. R. Fouts, of English, is now stationed at the Naval Hospital at Fall Brook, California. His address is in care of the Naval Ammunition Depot there. He reports having to work harder there "than when the shooting was going on," due to the numerous and varied types of cases being sent there for treatment.

Discharged in January, 1946, with the rank of major, Dr. Eldore M. Hoetzer is now engaged in the practice of medicine in New Haven. He was with the 183rd Hospital Corps in Alaska for thirty months, and then was stationed at Gardiner General Hospital, in Chicago, for one year. At the time of his discharge, Doctor Hoetzer served as chief of the orthopedic section at the Gardiner General Hospital.

Released from active duty on March first, Lieutenant Roy V. Pearce soon will begin the practice of medicine in Franklin. Doctor Pearce entered the service in August, 1943, at the Naval Hospital on Treasure Island, San Francisco, and was later attached to an LST, the *U.S.S. Epping Forest*, as medical officer. During twenty-two months of sea duty, Doctor Pearce participated in eight major operations and landings in the Asiatic-Pacific theatre. Upon his return to the United States he was assigned to the Personnel Separation Center, at Great Lakes, Illinois.

Formerly a captain in the Medical Corps, Dr. Herbert L. Cormican, of Elkhart, has been released from service and has resumed his practice in Elkhart.

Major Harry Pandolfo is another Indianapolis physician who has been released from service and returned to his practice. Doctor Pandolfo entered the Army on July 4, 1942, and was stationed at the Army Air Forces Regional Hospital, at Lincoln, Nebraska, until December, 1945, when he was transferred to the Scott Army Air Field, in Illinois.

Following his release from the Army, after forty-two months in the service, Dr. Edward C. Lidikay, of Indianapolis, has announced the reopening of his office there. Before going overseas Doctor Lidikay was stationed at the Gulfport, Mississippi, Field Station Hospital, and later served in France, Luxembourg, and Germany.

Lieutenant Colonel William M. Loehr, of Indianapolis, is now practicing radiology in the Hume Mansur Building, following his recent release from the service. Doctor Loehr served as chief of the Roentgenology Service with the 179th General Hospital, and was in the service for five years, fifteen months of which were spent in the ETO.

After serving for more than forty-five months with the Army Medical Corps, Lieutenant Colonel Alan L. Sparks, of Indianapolis, has been released from service and has reopened his office in the Hume Mansur Building. He was stationed at Billings General Hospital, at Fort Benjamin Harrison, from May, 1942, until March, 1944, when he was transferred to Camp Knox to join the 111th General Hospital, which was being trained for overseas service. He was in England from July, 1945, until after V-E day, when he was returned to the United States, and he was again assigned to Billings General Hospital.

Now on terminal leave, Lieutenant Commander Andrew M. Brenner, of Winchester, has resumed the practice of medicine there. Doctor Brenner was called to active duty in September, 1942, and served as medical examiner for recruiting stations at Chicago and Springfield, Illinois, and then was assigned as senior naval medical officer at the Army-Navy stations in Peoria, Illinois, and Akron, Ohio. In 1943 Doctor Brenner received the designation of flight surgeon and was stationed at the Naval Air Station, in Minneapolis, Minnesota, and the Marine Air Base, in El Centro, California. He went overseas with Marine Fighter Squadron 462. He participated in the invasion of Iwo Jima, and during the General Pacific operations his squadron maintained a rear base at Tinian, in the Marianas. Later he was assigned to a Marine fighter squadron which received a Presidential Unit Citation for its work in the liberation of the Palau Islands.

After forty-three months of service in the Army Medical Corps, Major Philip J. Rosenbloom, of Gary, has reopened his office at his former location. Doctor Rosenbloom was with General Walter Krueger's famous 6th Infantry Division in New Guinea. He is also a veteran of World War I, and his World War II decorations include the combat medical medal; the World War, American Theatre, Asiatic-Pacific and Philippines liberation ribbons; and three battle stars.

Captain Alan R. Chambers, of Fort Wayne, has resumed the practice of medicine there, after having served for three and one-half years with the Army. Doctor Chambers was called to active duty in June, 1942, and joined the medical staff of the Third Armored Division. He went overseas with that unit in September, 1943, and returned to the United States in March, 1944. From that time until his recent return to inactive status, he served at the Kennedy General Hospital, in Memphis, Tennessee.

Commander Lester D. Bibler, of Indianapolis, has been appointed senior medical officer at the Jacksonville, Florida, Naval Personnel Separation Center. Doctor Bibler reported for active duty in November, 1940, and has served as medical officer for the Marine Corps Second Defense Battalion, as senior medical officer for the Second Marine Brigade in American Samoa, British Samoa, and Wallis Islands. For the last eight months he has served as head of the Neuropsychiatric Department of the Naval Hospital at Palm Beach, Florida.

After forty-five months in the service, thirty-three months of which were spent overseas, Dr. George E. Brown, of Greenwood, has reopened an office for the general practice of medicine. In 1942 he was sent to Trinidad, B. W. I., where he served for twenty months as a medical officer and adjutant of the 255th Station Hospital. In 1944 Doctor Brown went to the Pacific Theatre of Operations as chief of medicine, and later became commanding officer of the 75th Field Hospital on Okinawa. He then served as island surgeon on Ie Shima.

Captain John F. Mills, of Wabash, has been released from the service, and has opened his office for the practice of medicine in Wabash. Doctor Mills entered the Army on July 23, 1942. He spent twenty months at Scott Field, Illinois, in the Station Hospital, and went overseas in March, 1944, being assigned to the 97th General Hospital, at Oxford, England. He was transferred later to the 58th General Hospital, and served in the campaigns from Normandy across northern France to the eventual location of the unit at Commercy, near Nancy. After V-E Day, Doctor Mills was transferred to the 132nd Evacuation Hospital at Munich, Germany, and returned to the United States on January 5, 1946.

Recently released from the Navy Medical Corps, with the rank of lieutenant commander, Dr. Stanley M. Hammond, of Portland, has opened his office there for the practice of medicine. He entered the service in May, 1942, and served with the Coast Guard overseas in the 4th Marine Division, and at the Navy Recruiting Station at Chicago.

A veteran of both World War I and World War II, Lieutenant Colonel William H. Garner, of New Albany, resumed his reserve status in the Army Medical Corps recently, following more than three and one-half years of active duty, most of which was spent as chief of the Surgical Service at the Camp Campbell Station Hospital. Doctor Garner received a citation for "Accomplishing highly professional assignments with distinction, Colonel Garner reflecting great credit on his profession and the military service."

Colonel John H. Greist, of Indianapolis, has resumed the practice of medicine, at 202 Hume Mansur Building, following his recent release from the service. Doctor Greist entered the service on January 17, 1941, and spent one year with the 38th Division, in Mississippi; then served as chief of neuropsychiatric service in the Army General Hospitals, at Springfield, Missouri, and Topeka, Kansas, for three and one-half years; and then was neuropsychiatric consultant for the 7th Service Command, at Omaha, Nebraska, until relieved from active duty, on March 1, 1946. He traveled over nine states, visiting hospitals throughout the nine states of the 7th Service Command. Doctor Greist intends to specialize in psychiatry, and will be equipped to do electro-encephalography when those instruments are available.

Having been released from the Army on March ninth, with the rank of lieutenant colonel, Dr. Kenneth E. Thornburg, of Indianapolis, is now on terminal leave, and has resumed the practice of internal medicine in the Hume Mansur Building. He entered the Army June 4, 1942, and went to the 50th Station Hospital on July 15, 1942, where he served as chief of medical service until March 19, 1945. On April 19, 1943, Doctor Thornburg went overseas, landing at Casablanca on April twenty-eighth, where he functioned until June 4, 1944. Still with the 50th Station Hospital, he next moved on to Italy, setting up there on July 25, 1944, where he was stationed at Leghorn, on the west coast. On March 20, 1945, he became commanding officer of the 99th Field Hospital at the same location. On July twelfth he was placed in command of the 34th Field Hospital, in Naples, then went directly to the Philippines, through the Panama Canal, landing on September 2, 1945. On October eighth they set up at San Jose, in central Luzon, where he remained until January 26, 1946, when he came home. Doctor Thornburg spent a total of four years in the Army, thirty-four and one-half months of which were served overseas.

MAJOR GARBER VISITS HIROSHIMA



T-shaped bridge on which it was planned to drop the Atomic Bomb, which fell only about two blocks away.



Atomic Bomb was supposed to have exploded over this dome.

The reinforced concrete building withstood the blast, but was burned from the fire.



These are the remains of three Japanese barracks in a row, and it is interesting to note that the buildings extended to the left, so that only the far walls remained.

One of the late returnees from the war theatre is Major J. Neill Garber, of Indianapolis, who has really been places during his service in the armed forces, and whose demeaner reflected the happy feeling, "The war is over and 'we' are home!" Note that we said "we," for he did not return alone, and as far as we know he is the first one of our returning physicians whose Army service became linked with matrimony, having been married on June 9, 1945, while at Aachen, Germany, to Leola Boden, of Cleveland, Ohio, who served as a First Lieutenant in the Army Nurse Corps. They were married in the chapel of the Thirty-second General Hospital, where they were both members of the staff at the time.

Major Garber entered the service on March 17, 1943, as chief of the Orthopedic Section of the Thirty-second General Hospital and remained with it until July, 1945, when he was transferred to the 224th General Hospital, at Marseilles, France.

From Marseilles he sailed to Manila, a forty-day cruise with only a four-hour stop in the Panama Canal Zone, but which still did not take him to his journey's end. However, it was more of a golden voyage than usual under such circumstances, for Mrs. Garber accompanied him as far as Manila. He remained in the Philippines until November, 1945, when he was sent to Kure, Japan, a former Japanese Naval Base Hospital, and was transferred to the 361st Station Hospital, where he served as chief of Surgery from December until his return to the States on March 20, 1946.

While in Japan he was located only twelve miles from Hiroshima, and the photographs incorporated herewith were taken by Major Garber. These photographs give evidence of the blast destruction as it was first seen about two and one-half to three miles from the center of the city. The city area proper was completely flattened and burned except for the reinforced concrete buildings. Even in them there was blast destruction of metal window frames, elevators, and elevator shafts. Blackened tree trunks were seen everywhere over the area. Many small, one-story, wooden frame houses have been constructed in the midst of the ruins since the bombing, and are used as homes and souvenir shops. Strangely enough, the Atomic Bomb had not affected the railroads in the town, and relief supplies were in there by rail soon after the explosion.

We believe that the following quotation will apply in Dr. Garber's case:

"By the canal in Flanders I watched a barge's prow
Creep slowly past the poplar trees; and there I made a vow
That when these wars are over and I am home at last
However much I travel, I shall not travel fast.

Horses and cars and yachts and planes;
I've no more use for such;
For in three years of war's alarms, I've hurried far too much:
And now I dream of something sure, silent and slow and large;
So when the war is over—why, I mean to buy a barge."



Small structures rebuilt following the destruction at Hiroshima.

Deaths

Arvill Wayne Bitting, M.D., of Bourbon, died on April twenty-first, at the age of seventy-five. He had retired from practice, having been ill for some time. Doctor Bitting was a graduate of the Medical College of Indiana, at Indianapolis, in 1900.

Archibald Brown, M.D., of Rochester, died on April third at the age of sixty-nine. Doctor Brown was a graduate of the Hahnemann Medical College and Hospital, in Chicago, in 1903. He had been an invalid since 1934, at which time he retired from practice.

David Nelson Conner, M.D., of Markleville, died on May first at his home, after an illness of four years. He was sixty-nine years of age. He was a graduate of the Indiana University School of Medicine, in Indianapolis, in 1910, and was a member of the Madison County Medical Society and the Indiana State Medical Association, and a Fellow of the American Medical Association.

Garner N. Druley, M.D., of Kokomo, died suddenly on April twenty-fifth, at his home, aged fifty-eight. He had practiced in Kokomo for twenty-two years, and was a veteran of World War I. He was a graduate of the Indiana University School of Medicine, in Indianapolis, in 1912. Doctor Druley specialized in urology, and was a member of the Howard County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Floyd I. Eicher, M.D., of Wakarusa, died at the age of sixty-one on April fifth. Doctor Eicher was a 1916 graduate of the Indiana University School of Medicine, and after serving in the Army Medical Corps in World War I he located in Wakarusa, and had practiced there ever since. Doctor Eicher was a member of the Elkhart County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Leo K. Ryan, M.D., of Gary, died on April twenty-fifth, in Mercy Hospital, after a short illness. He was fifty-three years of age. Doctor Ryan graduated from Northwestern University School of Medicine, in Chicago, in 1916, was a veteran of World War I, and was a member of the American College of Surgeons. He was a member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Ernest R. Luckett, M.D., of Marengo, died on March twenty-eight, at Martinsville, shortly before his seventy-seventh birthday. He had practiced in Marengo for thirty-six years after graduating from the University of Louisville School of Medicine, in 1894.

Simon P. Scherer, M.D., of Martinsville, died on May third, at the age of eighty. He had been ill for more than three years. Doctor Scherer was a graduate of the Central College of Physicians and Surgeons, at Indianapolis, in 1891, and was a member of the Madison County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Shelton G. Silverburg, M.D., of Evansville, died on April fourth at the age of fifty-five. Doctor Silverburg was graduated from the Indiana University School of Medicine, in Indianapolis, in 1929, after having served overseas during World War I. He served with the Veterans Administration, having been with the hospitals at Marion, Indiana; Canandaigua, New York; Gulfport, Mississippi; and Waco, Texas. Two years ago he entered the private practice of psychiatry and neurology at Evansville. Doctor Silverburg was a member of the American Psychiatric Association, the Vanderburgh County Medical Society, and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Vincent A. Lapenta, M.D., of Indianapolis, died on April twentieth after a short illness. He was sixty-two years of age. Doctor Lapenta was born in Naples, Italy, and was graduated from the Regia Universita di Napoli Facolta di Medicina e Chirurgia in 1906. Shortly after graduation he came to the United States, and in 1911 took up the practice of abdominal surgery in Indianapolis. For discovering a serum for the control of hemorrhage, Doctor Lapenta was decorated as knight commander of the Order of the Crown of Italy, and received the same decoration from Roumania. He was also a member of the State-Governing Commission of the Gorgas Memorial Institute of Tropical and Preventive Medicine. A Fellow of the International College of Surgeons, Geneva, Switzerland, Doctor Lapenta was senior regent for Indiana and chairman of the Board of Trustees and Council of Examiners of the United States Chapter. He was also a Fellow of the Indiana Academy of Science, the Royal Society of Arts (England), and the American Medical Association. He was a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association.

News Notes

Having recently completed a residency in surgery at the City Hospital, in Indianapolis, Dr. James P. Powell has opened an office at 308-9 Glass Block Building, in Marion.

Dr. Jean F. Hinchman has located in Parker for the practice of medicine. For the past year he has been associated with the Moore Clinic, in Muncie, following a year's residency at the Ball Memorial Hospital in Muncie.

Five Indianapolis physicians are sharing office space at 1015 Hume Mansur Building. They are Drs. Harold M. Trusler and Thomas B. Bauer, who will be associated in surgery, with special attention to plastic surgery; Dr. D. S. Megenhardt, who will do general surgery; and Drs. Paul G. Iske and K. E. Thornburg, who will limit their practice to internal medicine.

For the second time Dr. Omer Wooldridge, of Kokomo, has announced his retirement from practice. In 1937 Doctor Wooldridge retired when his health failed, but returned to practice during the war years to help relieve the shortage of physicians. He has now decided to return to retirement for reasons of health.

Dr. L. E. Burney, State Health Commissioner, announces the opening of a second branch office of the State Board of Health, this being located in Valparaiso, and will serve seventeen counties. Dr. W. C. Anderson, of Mentone, will be in charge of this branch. Other branches are to be opened later, in Fort Wayne, Terre Haute, and Washington.

The Indiana Hospital Association held a meeting in Chicago on May first, in conjunction with the Tri-State Hospital Association, at which Dr. Charles W. Myers, superintendent of the Indianapolis City Hospital, assumed his duties as president. Sister Andrea, administrator of St. Vincent's Hospital, Indianapolis, was named president-elect.

An appeal to young women to enter the nursing profession was made by Sister Miriam Dolores, superintendent of nurses at St. John's Hickey Memorial Hospital, in Anderson, in an address made in observance of Florence Nightingale's birthday, May twelfth. Sister Dolores said, "The profession is entering upon a new and important phase of its development. Our war experiences have greatly enlarged the theater of the nurses's activities. The graduate nurse of the future will have a choice of many rehabilitation and public health services in Europe and Asia. She will easily become a citizen of the world."

A veteran of the Spanish American War and World War I, Dr. Thomas Z. Ball, of Crawfordsville, has been appointed national surgeon of the United Filipino Veterans. The organization has headquarters at Minneapolis.

Dr. Kathryn Whitten, who has practiced in Fort Wayne for thirty years, has retired from practice and gone to California to live. Doctor Whitten plans to do all the things she wanted to do during the time she was in practice, including extensive travel in Europe.

Returned World War II Army and Navy Medical Corps physicians have formed a Madison County chapter, which is reported to be the first group of its kind established in that section of the state. Dr. Paul T. Lamey, of Anderson, was elected president; Dr. J. C. Drake, of Anderson, vice-president; and Dr. Robert L. Armington, of Anderson, secretary-treasurer. All Madison County physicians who served in World War II are eligible for affiliation with the chapter, which will meet the last Monday in each month.

Members of the newly-created State Board of Medical Registration and Examination, appointed recently by Governor Gates, include the following physicians: Dr. Will A. Thompson, Liberty; Dr. William N. Wishard, Jr., Indianapolis; Dr. Howard C. Ruddick, Evansville; Dr. Paul R. Tindall, Shelbyville; and Dr. H. W. Eikenberry, Indianapolis. Created by the last session of the legislature, and replacing the existing board, this board has control, supervision, and jurisdiction over licensing and registration of Indiana doctors.

Dr. Walter F. Kelly, of Indianapolis, will soon bid goodbye to a host of Indianapolis friends, after nearly forty years of practice in the Irvington district. Doctor Kelly's plans call for his retirement sometime in mid-June, when he will go back to New England, where he was born, and live on his seventy-acre farm in "Squash Hollow," a few miles from New Milford, Connecticut. During the four decades of his practice, Doctor Kelly hasn't missed a day because of illness. He was president of the Indianapolis Medical Society in 1933; a member of the Council for three years; chairman of the Constitution and By-Laws Committee for more years than he can recall; a member of the House of Delegates of the Indiana State Medical Association for eight years, and alternate delegate to the American Medical Association for the same length of time. Doctor Kelly is retiring with a career behind him which few achieve and which all will envy.

The Whiting Clinic, of Whiting, has reopened, since Doctors John L. Ferry, Donald H. Rudser, and Edmund N. Walsh have returned from military service and established their offices in the Central Building, in Whiting.

NARCOTIC LICENSE RENEWAL DUE JULY FIRST

Physicians registered under the narcotic law are hereby reminded that their re-registration form, their annual tax of one dollar, and their inventory Form 713, showing drugs on hand, must be in the office of the Collector of Internal Revenue by July first.

AMERICAN CONGRESS OF PHYSICAL MEDICINE

The American Congress of Physical Medicine will hold its twenty-fourth annual scientific and clinical session on September 4, 5, 6, and 7, inclusive, at the Hotel Pennsylvania in New York. Scientific and clinical sessions will be given each day. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 4, 5, and 6. These courses will be open to physicians and to therapists regstered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

Dr. Carl Kuehn, of Muncie, who graduated from the Indiana University School of Medicine in 1941, and who was recently discharged from the United States Army with the rank of major, has been named resident physician of the Logansport State Hospital, at Logansport, according to an announcement by Dr. C. C. Chapin, the superintendent of the institution.

BEWARE OF RACKETEER!

The following warning has been received from one of our members and warrants publication. We quote:

"The purpose of this letter is to inform you and our brother practitioners of a racket recently perpetrated upon one of our local physicians.

"This racketeer makes his appearance at a local hospital. Having obtained a name of a local surgeon, he inquires of the hospital authorities if the doctor is in. He further inquires if anyone is operating. Being well-dressed and of professional appearance, he is easily mistaken for a visiting physician. He then makes his way to the surgeons' dressing room, and finding nobody there, rifles the pockets of any clothing available. He then is liable to make his appearance at the office to have a bill changed, or he may mix with visiting relatives or friends of patients in the hospital, and leave with them; this latter procedure to allay suspicion."

"CALIFORNIA, HERE WE COME!"

More than sixty-five reservations for the seventeen-day vacation and sightseeing trip to the American Medical Association meeting in San Francisco, July 1 to July 5, returning by way of Lake Louise and Winnipeg, Canada, had been received at the state headquarters' office of the Indiana State Medical Association up to May 25. Indications were that at least a hundred would be in the "Indiana Party."



Hotel at Banff National Park, Canada, in the Canadian Rockies.

The train will leave Indianapolis at 1:30 P.M., Central Standard Time, Tuesday, June 25. Many from northern Indiana will board the train at Chicago. It will leave there at 9:15 P.M., Central Standard Time.

Reservations will be accepted as long as there are Pullman accommodations available. Information about the tour, including itinerary and cost, was published on Page 251 of the May JOURNAL. Persons who are interested in taking the trip should contact Ray E. Smith, executive secretary, Indiana State Medical Association, 1021 Hume Mansur Building, Indianapolis 4, Indiana.

A physician may deduct the amount of his expenses to San Francisco from his Federal Income Tax returns on the grounds that he is attending a scientific meeting.

Dr. W. B. Wood, who assumed the practice of his son, Dr. R. W. Wood, in Oakland City, when he went to service, has retired from practice and returned to his former home in Princeton.

Dr. J. H. Stamper, of Middletown, recently returned from the East, where he took postgraduate work in Anesthesia at the Massachusetts General Hospital, in Boston, and at the George Washington University School of Medicine, in Washington, D.C. He is now doing anesthesia at St. John's Hospital, in Anderson, but will continue his residence in Middletown.

STATE-WIDE CONFERENCE ON "RURAL MEDICAL CARE" IS PLANNED

Ground work was laid for a state-wide conference of medical and agricultural leaders, to consider the problem of "Rural Medical Care," at Purdue University, Lafayette, next August, at a meeting of the Committee on Rural Medical Care of the Indiana State Medical Association and the Medical Care Committee of the Indiana Farm Bureau, in Indianapolis, on April seventh.

Physicians present at the committee meeting were Dr. H. N. Smith of Brookville, chairman of the Committee on Medical Care; Dr. I. H. Scott of Sullivan, Dr. George V. Cring of Portland, and Dr. Stuart R. Combs of Terre Haute—all members of the committee; Dr. F. S. Crockett of Lafayette, chairman of the Committee on Rural Medical Service, American Medical Association; and Dr. L. E. Burney, state health commissioner.

Others at the meeting were Hassil E. Schenck of Lebanon, president of the Indiana Farm Bureau; Jack J. Rosebrough, chairman of the Medical Care Committee of the Indiana Farm Bureau; Mrs. Alice Womacks of Valparaiso; Anson Thomas, director of the Tax and Legislative Department, Indiana Farm Bureau, Ray E. Smith, assistant executive secretary of the Indiana State Medical Association—all members of the committee; and M. H. Ringer, general manager of the Hoosier Farm Bureau Life Insurance Company.

The proposed conference at Purdue would be under joint sponsorship of the rural medical care committees of the Indiana State Medical Association and the Indiana Farm Bureau; the Department of Agriculture, of Purdue; the Indiana State Board of Health, and various health organizations. The conference would be open to all persons interested in the problem of rural health.

The need for counties to erect health centers or small hospitals in rural communities where beds, laboratory, and x-ray facilities would be available was discussed. The committees decided that encouragement should be given such projects, for such centers would give the people better medical care, and physicians would be attracted to towns having facilities where patients could be treated adequately.

INDIANA UNIVERSITY NEWS NOTES

Eighty-two members of the senior class of the Indiana University School of Medicine received the M.D. degree April twenty-third. This was the final wartime accelerated class graduated by the University. The members participated in the University's February commencement; took their State Medical Board examinations April 25-27; and now have begun to serve their internships in various hospitals. Their completion of the medical course brings to an end a period in the history of the Indiana University School of Medicine during which the school, called upon by the armed services to meet the wartime need for more physicians, trained students in uniform and graduated 744 in four years.

Students who received the M.D. degree and where they will serve their internships are as follows:

Indiana University Hospitals, Indianapolis: James A. Acos, Evansville; Roy H. Bohnke, Mishawaka; Edward J. Berman, Indianapolis; Christ A. Blassaras, Anderson; Robert J. Forbes, Martinsville; Marjorie J. Galliher, Muncie; John T. Harbaugh, Bloomington; Harold N. Johantgen, Indianapolis; Philip A. Lahr, Mishawaka; Louis J. Makielski, Mishawaka; Anne S. Nichols, Greencastle; Thomas V. Reese, Indianapolis; Henry J. Rusche, Evansville.

Indianapolis City Hospital: Donald P. Bixler, Decatur; James Bopp, Terre Haute; Richard W. Dyke, Fort Wayne; Duke E. Hanna, Jr., and Ray A. Henn, Ligonier; James E. Hull, Columbia City; Dale S. King, Indianapolis; George C. Poolitsan, Bloomington; Thaddeus T. Richardson, Indianapolis; John R. Scott, Indianapolis; Charles F. Smith, Kokomo; George V. Teter, Jr., Fort Wayne; and Harry D. Webb, Anderson.

Methodist Hospital, Indianapolis: George H. Belshaw, Indianapolis; Robert E. Bryan, Marion; Harold R. Griffith, Vevay; Eugene L. Hendershot, Evansville; Maurice C. Jannasch, Gary; Donald M. Kerr, Knox; Clarence R. McIntire, Indianapolis; Arvine G. Popplewell, Indianapolis; Donald L. Rogers, New Ross; William C. Seagle, Indianapolis; and Maurice A. Turner, Indianapolis.

St. Vincent's Hospital, Indianapolis: Paul Chasman, Indianapolis; Jack R. Diamond, Indianapolis; Paul J. Kirkhoff, Indianapolis; William M. Matthews, Indianapolis; Leonard V. Phillips, Thorntown; Martin A. Seidell, Indianapolis; William B. Turner, South Bend; Charles J. Van Tassel, Indianapolis.

St. Catherine's Hospital, East Chicago: Clifford A. Beilke, Indianapolis.

St. Elizabeth's Hospital, Lafayette: Charles E. Boonstra, Lafayette; Frank C. Donaldson, Lebanon; and John S. Fifer, Indianapolis.

St. Joseph's Hospital, South Bend: William H. Davis, Evansville; and James R. Guthrie, Greensburg.

Lutheran Hospital, Fort Wayne: John F. Jackson, Fort Wayne.

St. Margaret's Hospital, Hammond: Bernard F. Poracky, Whiting.

The following will serve their internships in out-of-state hospitals: Robert K. Allen, Akron, Ohio, Wesley Memorial Hospital, Chicago; Edward J. Brockman, Indianapolis, St. Mary and Elizabeth Hospital, Louisville, Kentucky; Stanton E. Cope, Winchester, Navy; Robert J. Crossen, Indianapolis, Harper Hospital, Detroit, Michigan; Marion C. Drake, Anderson, Wisconsin General Hospital, Madison, Wisconsin; James O. Futterknecht, Mishawaka, Harper Hospital, Detroit, Michigan; Ben Gaber, Detroit, Women's Hospital, Detroit, Michi-

gan; Orville M. Graves, Princeton, Santa Rosa Hospital, San Antonio, Texas; Frederick L. Harcourt, Milroy, St. Joseph Hospital, Phoenix, Arizona; Albert W. Hilberg, Michigan City, Evangelical Hospital, Chicago; Harland V. Hippensteel, South Bend, Navy; C. Eugene Jackson, Dayton, Ohio; Scott and White Hospital, Temple, Texas; Murray Jonas, Brooklyn, New York, Kings County Hospital, Brooklyn, New York; Charles M. Kerr, Bloomington, Philadelphia General Hospital; Bruce A. McArt, Anderson, Greenpoint Hospital, Brooklyn, New York; William G. McDonald, Kirkland, Harper Hospital, Detroit, Michigan; Esther McGinness, Evansville, taking no internship for the present; Richard J. P. Markey, East Chicago, San Diego County (California) General Hospital; George W. Mellinger, Indianapolis, Massachusetts General Hospital, Boston; Bobby Lee Moss, Indianapolis, Navy; Mary E. Rhamy, Wabash, taking no internship; Siegfried Sheldon, Irvington, New Jersey, Newark City (New Jersey) Hospital; John A. Shively, Rossville, Philadelphia General Hospital; Frank O. Sisler, Gary, Grace Hospital, Detroit, Michigan; Berl B. Ward, South Bend, Wayne County Hospital, Eloise, Michigan; Richard J. Waters, Logansport, Philadelphia General Hospital; James W. Weatherholt, Fort Wayne, California Hospital, Los Angeles; Roy M. Whitman, New York City, Kings County Hospital, Brooklyn, New York; and William H. Zimmerman, Indianapolis, Evangelical Deaconess Hospital, Detroit, Michigan.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

April 14, 1946

The Council of the Indiana State Medical Association convened for its spring meeting at 9:45 A.M., Sunday, April 14, 1946, in the Columbia Club, at Indianapolis, with Dr. A. M. Mitchell, of Terre Haute, chairman, presiding. Roll call showed the following present:

Members of the Council:

First District—I. C. Barclay, Evansville
Second District—Not represented
Third District—A. P. Hauss, New Albany
Fourth District—C. F. Overpeck, Greensburg
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—W. H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne
Thirteenth District—Not represented

Officers:

J. E. Ferrell, Fortville, president.
Floyd T. Romberger, Lafayette, president-elect.
A. F. Weyerbacher, Indianapolis, treasurer.
E. M. Shanklin, Hammond, editor of THE JOURNAL.
C. A. Nafe, Indianapolis, chairman, Executive Committee.
C. H. McCaskey, Indianapolis, member, Executive Committee.
Albert Stump, Indianapolis, attorney.
T. A. Hendricks, Indianapolis, executive secretary.
Ray E. Smith, Indianapolis, assistant executive secretary.

Guests:

C. A. Stayton, Indianapolis, chairman, Committee to Study Cancer Clinic Situation.
Paul Garber, South Whitley, chairman, Building Committee.
B. F. Pence, Columbia City, president Whitley County Medical Society.
C. F. Thompson, Indianapolis, Veterans Fee Schedule Committee.
Gordon Batman, Indianapolis, chairman, Committee on Convention Arrangements.
J. William Wright, Indianapolis, co-chairman, Legislative Committee.
F. S. Crockett, Lafayette, chairman, Committee on Rural Medical Service, A.M.A.
Walter F. Kelly, Indianapolis.
M. R. Lohman, Fort Wayne.
W. L. Portteus, Franklin.

Upon motion of Dr. Clark, seconded by Dr. Sparks, the minutes of the Council meetings held at Indianapolis on January 13 and January 27, 1946, were approved as printed in the March, 1946, issue of THE JOURNAL.

SPECIAL ANNOUNCEMENTS

DR. MITCHELL: The Headquarters Office has been considering a trip to the A.M.A. meeting in San Francisco, and has a schedule of a train trip conducted by the Chicago and Northwestern, out of Indianapolis, using a special train. The approximate cost will be around $300.00. It includes Pullman, railroad ticket, hotel accommodations in Los Angeles and other places, including sightseeing trips, but does not include hotels or meals in San Francisco or meals on trip. I think this should be publicized to the profession, so that if any doctors want to go it can be done as a happy family. It takes seventeen days. You can have a special train, or if there is only enough for one coach, or two, or ten, they will take it on that basis. Ohio is doing the same thing.

(Motion made by Dr. Clark, seconded by Dr. Black, and carried, that this trip be publicized.)

Dr. Mitchell read a telegram from Dr. Alfred Ellison, of South Bend, to the effect that he was unable to be present.

REPORTS OF COUNCILORS BY DISTRICTS

The councilors had nothing to report on district activities.

Dr. Hauss announced that the Third District meeting would be held on May 22 at Bedford and that they would like to have not only the president but the president-elect at that meeting.

Dr. Sparks called attention to the membership

problem in his district which was listed for discussion later in the program. He announced that the Twelfth District meeting would be held at Fort Wayne on April 30.

REPORTS OF OFFICERS

DR. FERRELL, president: In appointing this committee on changing the constitution, in regard to more democratic problem of electing the officers, which was a committee delegated to be appointed, I would like to have suggestions from each of the Councilors of men who they think would be useful on that committee. It is pretty hard for me to select the men, because I think that is a very important committee. We could get into a lot of confusion if we are not careful, and I would like to have every Councilor suggest some good man from his District that should be appointed on that committee.

DR. ROMBERGER, president-elect: As ex-officio member of the Council, I enjoy the highly enviable position of having nothing to do, sitting by, etc. I would like to report on a few things which, to me, should be of interest to this Council. I was guest speaker at South Bend at the Tri-State meeting, and I met Dr. Sensenich there and had a three or four hour discussion with him. Since the first of the year I sat in at the business meetings of five different County Medical Societies. I want to say this to you Councilors. My impression from these County Medical Society meetings is this: there is a decided lack of information and knowledge of the problems which are confronting us in medicine today, and in a great many of these County Societies momentous problems are passed with little or no discussion. For instance, with regard to the Maternal Welfare contract, in those counties where the fees for obstetrics were below the $40.00 which the government promised to pay, they accepted it with glee, and in those counties where the $40.00 was slightly below, or considerably below, it did not set quite so well. The same thing is true of this Veterans Bureau contract which is proposed, and there are many, many, little Ethiopians in the woodpile, which I shall be glad to discuss when the Council takes up this problem.

Another thing I wish to say is that in this term of president-elect I shall be very happy to cooperate with our president and assist him in anything he may ask me to do. Indeed, I have offered, and I think it should be that the State Headquarters, through the president and president-elect, should be represented at every District Meeting, and I have offered my services to Dr. Ferrell to assist him in doing this. I don't know that it is necessary for both of us to be there, and I think Dr. Ferrell should have the honor and prestige which goes with the office, in having first choice. I would like to say to you Councilors that it is an idiopathic, diseased condition of some kind—I can't quite define it—where you ask the president of your State Society to come there and you introduce him: "Gentlemen, we will give our president two minutes to address you." I don't know how to name the disease, but that is not a respectful way to have your president visit you, and when you organize your District Society Meetings, give him a definite place and period of time on your program. He is entitled to that honor and that respect and then he feels he has done something worthy of the time, which may be a twenty-four hour period away from his business, to come before your Society. As far as I myself am concerned, my concern is for the more firmly established unity and structural strength of our County Medical Societies. A weak County Society makes for a weak State Society. If we are directed in Indiana from Indianapolis how to practice medicine in our respective counties, then the people will want good medical protection. We must have unity in our County Societies, and we must have information carried to our County Societies, so they may rise up on their hind legs and voice their opinions. I wouldn't presume that Tippecanoe can practice in Marion county, and I defy Marion to practice in Tippecanoe. This fact has been revolving in my mind for a long period of time, and it is becoming more intelligible. I think when, as, and if mother-in-law comes to visit us, the County Medical Society should be the ruling factor in that particular county.

DR. WEYERBACHER, treasurer: You perhaps noticed the Auditor's Report in the March JOURNAL, and we are again moderately in the black. As things are going we will be in better shape shortly. Somebody asked me about the so-called $10,000.00 Emergency Fund set aside at the last French Lick meeting. Truly it isn't set aside, except that there is a rubber band put around $10,000.00 in our holdings. There was no need to set up another fund in another bank. It is available for these threatened emergencies discussed in French Lick. None of those has arrived to date. You will be interested to know about our Loan Fund, created at that time to lend any returned serviceman in good standing up to $500.00, available at 4 per cent. Now it is discussed that this will probably be 3 per cent. So far there have been only three applicants. One was not eligible because he had never been a member; the other two have been taken care of, and we have eliminated red tape to the extent that they receive the money very promptly.

DR. SHANKLIN, editor of THE JOURNAL: At French Lick a committee was appointed from this body to consult with the editor of THE JOURNAL, suggesting that the editor should name a man to serve as associate editor of THE JOURNAL. I told the committee (I saw Dr. Mitchell and Dr. Ellison, the two members of the committee) that I felt that there were some things that should be considered. The man to be named should have a rather extensive medical association background; he should have certain abilities and whatnot, and that I would prefer that the members of the Council submit names of men whom they would recommend for that position. I had, from the Council, three names submitted. In addition to that, I had two others that

I felt should be very seriously considered, the first of whom, Dr. Giordano, of South Bend, flatly refused to take on any more jobs. He had too much to do as it was. I talked to a lot of men and wrote several letters over the state, and finally determined to name one of my own townsmen, Dr. Forster, and submitted that recommendation, after considerable time, to the members of the committee. I would like your reaction on that suggestion at this time.

(Motion made by Dr. Black, seconded by Dr. Clark, and carried, that the nomination and election be approved.)

We have a matter that has been under consideration by a special committee for a matter of a little more than three years. I refer to the Cooperative Medical Advertising Bureau, an adjunct of the A.M.A. I think that you all have a copy of the principles that were finally adopted, after a matter of three years. This Cooperative Bureau was organized by the A.M.A. some twenty-five years ago, and for a good many years was conducted on a hit-and-miss basis. Dr. Olin West, the secretary and general manager of the A.M.A., and Will Braun, the general manager of the Business Department of the A.M.A., and Walter Vest, of the West Virginia Association, were members of the committee. As a matter of fact, a few years ago a little group of this Cooperative Bureau discovered that the whole thing was managed and operated and controlled by the A.M.A. There are thirty-five State Association Journals in this Cooperative Bureau, and three years ago a group of us got together. We felt that the Journals ought to have more to say about the policies of the Bureau, particularly in the matter of restriction of advertising on the part of the Council on Pharmacy and Chemistry. As a result of these little preliminary correspondence conferences, we asked for a meeting in Chicago three years ago last summer, and it devolved upon a couple of individuals, one known later as the "Hoosier Hurricane" and the "Indiana Screwball," who went to the front at that meeting, and we had quite an open fight on that thing. As a result of that meeting, in the Palmer House, over three years ago, a committee of three was named, including Walter Vest, who was then on the committee; Stanley Weld, editor of *The Connecticut Journal;* and myself, and we had meetings for a period of nearly two years, but we didn't get very far. Tom knows all about this. Finally, we came to a showdown and demanded a greater representation on the part of the thirty-five Journals, and the three above named, with John Bouslog, of Denver, and Fernald Foster, of Michigan, were named to the committee. At our next meeting we did not get anywhere at all, due to the same stonewall, and in the meantime they called in the secretary of the Council on Pharmacy, Austin Smith. It was only last February that we had another meeting, and then we had our way about things, and we reorganized the whole committee, so that the committee now stands with the five secretaries or editors, or both, as named, with Morris Fishbein, Austin Smith, secretary of the Council, and George Lull, the new secretary and general manager of the A.M.A., as ex-officio members. So from now on this Cooperative Committee (I happen to be on for two more years, so it won't last long, you can't be re-elected to it) will be in absolute control of the Cooperative Bureau.

Now, just a word as to what this Cooperative Bureau is doing. The Cooperative Bureau advertising increased from a matter of $200,000.00 to $556,000.00 a year in 1945, which was distributed pro-rata among the thirty-five state journals. We have a new secretary and acting director, Alfred Jackson, who formerly was connected with the mechanical department of the A.M.A., and in whom the committee has great confidence, and in a letter received from Jackson last week he stated that already this year we have increased the advertising revenue some $50,000.00, so that we are now operating as a $500,000.00 corporation. I can not give you the amount of the receipts for Indiana for last year, but it will be a sizeable sum for 1946, probably about $15,000.00, which will be our share of the Cooperative income.

In this reorganization we spent two days up there in February, going over this thing, and this was changed about six or eight times, until we finally came down to the copy which you have here. There are five active journal publication men (Colorado, Michigan, Indiana, West Virginia, and Connecticut), in control of this program. First I might say that last fall we had an all-day meeting with the Board of Trustees of the A.M.A., and we got what we wanted. Then we were called in a month later for an all-day meeting with the Council on Pharmacy and Chemistry. For example, in 1945, the Ciba Company submitted three pages a month of advertising to our JOURNAL—that is, "Your" JOURNAL. I shouldn't say "our," I was criticized for that: it is "Your" JOURNAL. They submitted three pages of advertising, but we could accept only one page because they advertised Privine. At this meeting with the Council on Pharmacy and Chemistry, when this matter was brought up, Morris Fishbein, the chairman of the Advertising Committee of the *A.M.A. Journal*, said, "Well, I don't know what is wrong with Privine. I use it." Five members of the Council sitting around there said they used Privine, and yet we could not advertise it. Then there were other items—Nembutal, we could not advertise Nembutal because Lilly's had brought out the same thing under a name that was more suitable to the Council on Pharmacy than Nembutal, and only since February have we been able to carry Privine and Nembutal in our JOURNAL advertising, and it means a great increase in our income. Another example, the matter of rectal suppositories. There are said to be three high type suppositories made. One man spoke up at this meeting of the Council and said, "If they would just change the wording of their advertisement a little bit, we would be glad to accept their

advertising, because when I go to a bridge party, and some woman asks me what is the best suppository to use, I tell her that any one of these three is good." I mention that to show one of the results of the activities of this committee. It already has resulted in a breaking-down of a great many barriers on advertising on the part of the Council on Pharmacy and Chemistry, which will mean an increase in the advertising profits of your JOURNAL. Along the same line I might say, and this is in Tom Hendricks' department—he is managing editor—that the advertising from various pharmaceutical and drug houses is still on the increase, and will be for another year, and that we will reap a big profit from it.

Those are highlights of what your committee has done. Instead of waiting from one year to as much as three years for approval of a product on the part of the Council, we have an agreement with them whereby we will get action in just a few months, sometimes in thirty days. Some pharmaceutical company brings out a new product, and instead of waiting two years for permission to advertise in our legitimate medical journals, they will sample you and sample me, which is an expensive process. Now, under the new regulations, they will submit their product to the Council, and we will get action in just a matter of thirty, sixty, or ninety days, instead of waiting two or three years. We have a provision that any one of the thirty-five journals which do not live up to this list of principles will have to drop out of the Cooperative Bureau. Tom, do you think of anything else?

MR. HENDRICKS: I think that is about the story. This Cooperative Bureau affair has been a key event in the movement to bring the state societies closer to the A. M. A. Doctor Shanklin and the committee spearheaded the attack. It was the Normandy-beach landing, and the Committee pushed on through and established an opening and bridgehead for advances along many other lines, which I believe will put the A. M. A. much closer to the state and the county medical societies.

DR. SHANKLIN: I am glad Tom said that, because this Cooperative Committee of five has opened the breach in the wall up there, and the other fellows are just clambering all over to get in. Tom's committee and various departments have climbed in before they could repair the breach. The point is this: this program will have to be OK'd by the states represented by the thirty-five cooperating Journals, and I seriously ask your O. K. on this program. We have spent more than three years on it.

DR. CLARK: I move that we approve the action of the Advisory Committee to the Cooperative Medical Advertising Bureau.

MR. HENDRICKS: You understand what that means. That means that you have to conform absolutely to the Council on Pharmacy and Chemistry and to the other Councils at the A. M. A. in their recommendations concerning advertising in THE JOURNAL.

DR. CLARK: As I understand it, it means good, sound advertising, and not fly-by-night advertising.

(Motion seconded by Dr. Barclay, and the motion carried.)

DR. NAFE, chairman, Executive Committee: Mr. Chairman and Members of the Council: The inevitable has happened. At the February meeting of the Executive Committee our Executive Secretary, Mr. Hendricks, informed us of the fact that the A. M. A. desired his services full time, a thing that had been foreseen by all of us when he went up there. They have asked if it were possible that he be released, because he is needed very badly by the A. M. A. Therefore, the Executive Committee recommends to this group that we accept, with regret, his resignation as of May 1, 1946.

The Executive Committee further recommends that Mr. Ray E. Smith be promoted to the position of Executive Secretary of the Indiana State Medical Association as of May 1, 1946. In anticipation of this change conferences have been held with the Indianapolis Medical Society. They were very reluctant to relinquish Mr. Smith's services, —finally consented to do so, with the understanding that Mr. Smith, who has done such a fine job here with the local society, be allowed more or less to supervise unofficially the office and keep it under his wing until the new man knows the ropes. I think this is a proper request of the State Association, and the Executive Committee recommends that this be approved.

I know that to the Executive Committee it was a peculiar feeling when Tom told us he was going to the A.M.A., and it reminded me of a story that Dr. McCaskey and I were told when we went to see Man of War. This old colored fellow had taken care of him for sixteen years, and we said to him, "We suppose you think that horse belongs to you." He replied, "I tells Mr. Riddell he owns him but he is my horse." It seems to me that we will always think that way of Tom; in his going to the A.M.A. we are being promoted into the field of affairs of the A.M.A., rather than losing him.

This would necessitate, of course, some other changes, which the Executive Committee would recommend. First, a reinstatement of Miss Kribs as Assistant Executive Secretary, a title she was given several years ago, and which she should carry again. It also means that we should review at this time the salaries paid in the headquarters and JOURNAL offices because they have not been reviewed for a year or so, and during that time some changes in the salaries of the employees elsewhere have taken place, and there is some feeling that some of the salaries of our employees should be changed.

We would recommend that our employees be paid on a monthly or yearly salary, rather than weekly, as at present, so that the checks would come every first and fifteenth.

I want to call to your attention that in the last couple of years two assistants have been added to THE JOURNAL office. They have been O. K.'d by

the Executive Committee. So there are three girls in that office. Dr. Shanklin feels this staff is necessary.

The management of THE JOURNAL is under Mr. Hendricks and Mr. Smith together, and now it will be under Mr. Smith. He is the manager of THE JOURNAL. That is the title: Executive Secretary and Managing Editor of THE JOURNAL, so that the lines of authority there should be well drawn, and the Executive Secretary and Managing Editor should have complete control of both offices and his recommendations should be accepted by this Council as to just how things are handled. In anticipation of the probability that the Council would accept these recommendations, there was some thought by Mr. Smith that the business management, and control of the business auditing of THE JOURNAL might well not be left in THE JOURNAL office, but put under a little different control. Miss Rokke should be more concerned with the editing and the material that goes into THE JOURNAL.

Therefore, we make these recommendations: first, that we accept, with regret, Tom's promotion; that Mr. Ray E. Smith be elevated to the position of Executive Secretary and Managing Editor of THE JOURNAL; that the salaries from now on be on a monthly or yearly basis, rather than on a weekly basis; that consideration be given to any changes in salary, and certainly this body must establish the salary for the new Executive Secretary, if he is placed in the full-time position.

MR. HENDRICKS: Mr. Chairman, Dr. Nafe, Gentlemen, Members of the Council: I think first and foremost the thing to say is to give you an official statement from the A.M.A., as nearly as I can give it to you without having it here in writing. The Board of Trustees of the A.M.A., at the recommendation of the Council on Medical Service and Public Relations, has asked me to head up the Council on Medical Service and Public Relations. At the present time the Council on Medical Service and Public Relations consists of the following: A Washington office, which is under the direction of the Council on Medical Service and Public Relations, and the Chicago office. A Division of Prepayment Medical Care, which is to carry out the voluntary sickness insurance program adopted by the Board of Trustees and the Council on Medical Service for the A.M.A., has been created within the Council. That Division is being headed by Jay Ketchum, who is the Director of the Michigan Medical Service Plans. Joe Lawrence heads the Washington office and is director of that office. A statement in regard to public relations and the functioning of the Council will be made at the July meeting of the A.M.A., and just what that will be no one can tell at the present time, except that the Board of Trustees of the A.M.A. has employed a man to do an over-all public relations survey. That man is Raymond Rich, an associate in New York. This survey is to be objective in its viewpoint. The idea was presented to Mr. Rich that any survey of American medicine should include a survey of the State and County Medical Societies, as well as the A.M.A., because truly the heartbeat of American medicine lies within the County and State Medical Societies, as Dr. Romberger has pointed out here today.

Officially I would say, first, I want to tell you that Olin West, who is the retiring Manager and Director and Secretary of the A.M.A., has asked me personally to express a deep word of appreciation to the Indiana State Medical Association, and to the Council, and to the Executive Committee, for the interim arrangement which was made, whereby I was loaned on a part-time basis to the A.M.A. That interim arrangement, although it has had, as you know, some handicaps, has I believe resulted in good for the most part, because it has clarified the situation at the A.M.A., and I believe allowed for a readjustment period here in Indiana, allowing Ray Smith, who has come in here and has taken over the job, to grasp the situation more effectively than almost any man I can conceive of. There has been some rather tragic experiences with laymen in the medical picture, and it has often come from the fact that you get laymen who have plenty of vim and vitality and fight and push, but who do not have the concept of the professional relationship, the professional viewpoint of the position. Now that is very, very difficult to obtain and no layman ever can obtain it completely. I feel that the Indiana State Medical Association is going to be carried on just as you desire it to be carried on here under Ray Smith.

Regarding the situation at the A.M.A. and how it ties in here, there is a change of management there. Major General George Lull, former Deputy Surgeon General of the U. S. Army, goes in as Managing Director of the A.M.A. He is functioning at the present time. He has been in military service. Having worked with Procurement and Assignment Service, and having known General Lull in the early days of the War, and working rather closely with him now, I will say that you will see within the A.M.A. an administration, an organization, a development, that will mark a now era in the American Medical Association. This comes under the overall direction of Dr. R. L. Sensenich. Roscoe, as you know, is Chairman of the Board of Trustees of the A.M.A. In the new A.M.A. we do hope that we will be able to develop additional methods of getting important information down to the individual physician. That is very, very difficult. I believe that perhaps you are going to see this: a development of a division of professional relations, as distinguished from public relations, inside the A.M.A. A start toward this already has been made by the Council on Medical Service and Public Relations through news letters, regional public relations conferences and public relations meetings at the A.M.A. office where grass roots opinions and desires were received from representatives of the various state societies. The News Letters are sent to men, picked by their own so-

cieties, who get these messages and translate them and bring them to the attention of the state and county medical societies.

There is a job at the A.M.A. to be done; it is a tough job, but I believe it can be done. The Council is now in a position, better than other organizations, to get this thing jelled up into a unit and make it truly an organization which will reflect the viewpoints of the individual physicians.

As far as I am concerned personally, I am proud of this, that any viewpoint that I have usually is a reflection of the Indiana viewpoint. I am not going to leave Indiana. My official residence is going to be Culver, Indiana. It is going to be my home, and I am a Hoosier, will always be a Hoosier, and will always (I hope) think as a Hoosier. I have been here for a long time. I don't know how many of you were here at the time I started, and it was in this very building. Dr. Shanklin was there; Mitch was there; Dr. Black was there; and I know there was a great deal of skepticism at having any fellow come in who wasn't a doctor. Whenever I got into too much trouble I could always count on your backing and your help to get me out. I do hope that you will feel that it has all been worthwhile, and I want you to know, in closing, that I always want to have some connection down here, in some form, in some way, in some manner, because I am going to need the backing of every single man here, up in Chicago.

So in closing, I merely want to say "So long, but not goodbye." Thank you very much. (Applause.)

DR. MITCHELL: Do I hear a motion to accept the resignation of Mr. Hendricks, to take place the first of May?

DR. CLARK: I move that we accept Mr. Hendricks' resignation as of the first of May, with the proviso that Mr. Hendricks agree to the honorary title of "Emeritus Executive Secretary."

(Motion seconded by Dr. Black, and carried.)

MR. HENDRICKS: May I make one more statement? I do want you all to know how much I appreciate the backing of every man here, and particularly I want you to know how much the Indiana State Medical Association owes to Miss Kribs. Miss Kribs, really, when times have been tough and things have been piling up on us, at convention times, legislative times, her whole background of help and of work there at the Association has meant more than anyone can say. I think you all know that if there has really been an Executive Secretary at the Indiana State Medical Association a lot of times, it has been Miss Kribs.

Miss Reid has been most helpful too. If you ever want to know anything about any physician or locality in Indiana, or anything in regard to medical organization and services, just ask Miss Reid. She is a walking medical encyclopedia of Indiana.

DR. MITCHELL: Do I hear a motion to employ Mr. Smith as of May first?

DR. CLARK: I would like to move that we appoint or select Mr. Smith as the new Executive Secretary. I think we are most fortunate in having a man as well grounded and as well trained under Tom, a man who has accepted responsibility, as Mr. Smith has.

(Motion duly seconded, and carried.)

DR. MITCHELL: Next recommendation is the change of salaries of the personnel of the headquarters office.

The Council voted to increase the salaries of the personnel in the headquarters and JOURNAL office, effective May 1.

Dr. Clark made the motion, seconded by Dr. Black, that the executive secretary be in complete charge of all personnel, and that he assign each employee to his or her duties as he believes is necessary, regardless of whether they are in the headquarters office or THE JOURNAL office. This motion was passed unanimously.

MR. SMITH: Gentlemen: I appreciate this honor and this opportunity. I feel a deep sense of responsibility in succeeding Mr. Hendricks and in helping you with the problems of the medical profession here in the State. I pledge to you my faithful cooperation, and I want to assure you I will do my very, very best. Thanks, again. (Applause.)

UNFINISHED BUSINESS

1. *Report on proposed plan for medical care of veterans in Indiana.* Dr. C. F. Thompson, chairman of the Committee for Medical Care of Veterans of the Indiana State Medical Association, elaborated on the plan for the medical care of veterans, and answered questions of the councilors.

Dr. Romberger suggested that the detailed schedule for anesthesia service as submitted by the Tippecanoe County Medical Society be included in the fee schedule which is submitted to the Veterans Administration.

DR. CLARK: Mr. Chairman, I move that Dr. Romberger's fee schedule be inserted in the anesthesia schedule of fees, and that Dr. Thompson be instructed to present our agreement to the Veterans Administration. (Seconded by Dr. Dodds, and carried.)

DR. MITCHELL: The question comes up at this time as to the signing of this agreement with the Veterans Administration, as to who should sign this agreement, so it can be presented.

MR. STUMP: So far as the Veterans Administration is concerned, I think they would make a request that it come from the president and the secretary.

DR. THOMPSON: They want at least three signatures, with the designation of the office of each signer below his signature.

Dr. Clark moved that the president, the chairman of the Council, the Executive Secretary, and the chairman of the Committee, sign the agreement

for the State Association. Motion seconded by Dr. Barclay, and carried.

2. *Report of Committee to Study Cancer Clinic Situation.* This committee was appointed by the president of the state medical association in accordance with the action of the House of Delegates at the November, 1945, meeting at French Lick. Dr. Chester A. Stayton, chairman of the committee, presented the following report:

"CANCER CLINIC SITUATION

"Cancer, its diagnosis and treatment, remains practically the same as it has for the past fifty years. The disease is fatal unless it can be destroyed before it reaches the blood or lymph streams or has extended beyond the site of the original growth into vital structures. The cause of the disease is not known and the only effective methods of treatment are surgery and x-ray and radium irradiation.

"For the last ten years the American Society for the Control of Cancer, through its Women's Field Army and working under medical direction, has been very active in promoting a program of education calculated to inform the general public of the early symtoms of cancer. This, in order that the individual so affected may secure treatment before the disease has extended beyond the original site. The Indiana State Medical Association has had a Committee on Control of Cancer since 1938. At about the same time the American Society for Control of Cancer was organized, and the American College of Surgeons set up standards for the organization and operation of diagnostic and treatment cancer clinics in approved hospitals. There are four such clinics in Indiana, located at the University and City Hospitals in Indianapolis, at the Protestant Deaconess Hospital in Evansville, and at the Epworth Hospital in South Bend.

"For the past six years there has been an ever-increasing demand from the various lay groups of the Field Army for clinic diagnosis and treatment. The Committee for Control of Cancer of the Indiana State Medical Association through these years has put forth a determined effort to keep this demand in its proper perspective to organized medicine. In 1940, the House of Delegates disapproved the committee's recommendation for approval of cancer clinics. In 1941, the House of Delegates accepted the Cancer Control Committee's report which carried the following statement: 'The State Association approval of diagnostic tumor clinics where local facilities (hospital, laboratory and x-ray) are available. Such clinics to be with the consent of the local medical society and staffed by local doctors. The Women's Field Army to be a cooperative agency.'

"The Reference Committee at the meeting of the House of Delegates on November 8, 1945, objected to the report of the Committee on Control of Cancer, page 85 in the handbook, and following discussion it was amended to read that the State Association approve the use of diagnostic clinics for cancer, but that these clinics be restricted to indigents; and further that a committee be appointed to study the cancer clinic situation and make a report at the next meeting of the Council.

"The American Cancer Society through its Service Division has the final approval on all projects in the field for clinics which get financial or other assistance from that organization, and has gone on record that it will not encourage or approve *diagnostic* or *treatment* clinics except in hospitals approved for this purpose by the American College of Surgeons. Eligibility and the question of fees in such clinics would necessarily be determined by the approved, sponsoring institution.

"*Detection, prevention* or *well-person* clinics have been advocated by the American Cancer Society and approved in principle by the House of Delegates of the American Medical Association at its meeting in December, 1945. These clinics are designed to detect abnormalities not producing sufficient symptoms to send the patient to the doctor. These clinics are not to diagnose or treat disease. No such clinics are to be established in any community except by doctors who are members of the state medical association and with the approval of the County Medical Society. The examination is to consist of a history and clinical examination. No surgery (biopsy), x-ray, or laboratory tests are to be made. The written report of the examination is sent to a physician designated by the individual and not given to the individual. (*J.A.M.A.*, page 1209, December 22, 1945) This is the type of clinic that has been conducted in Indiana and has been open to the public by appointment, with or without reference by a physician, and no fee has been charged.

"In Indiana, the State Board of Health as yet has no definite cancer program; it is included in the new Department of Geriatrics. Fifteen states have definite Board of Health cancer programs, and in at least five states the Board of Health is operating some type of cancer clinic. Four states have cancer commissions separate from the Board of Health to administer the cancer program. In many of our larger cities, Chicago, New York, and Philadelphia in particular, many different types of cancer clinics are in operation. Most of these charge a small fee, and the patient may or may not be referred by a physician. In New York, the Strange Cancer Prevention Clinics have been in operation five years. A small fee is charged and 41 per cent of the patients seen have been referred back to their private physician for further medical care. In Philadelphia, the Health Maintenance or Cancer Prevention Clinics are sponsored by the International Cancer Research Foundation, and a fee of $10.00 is charged. These patients may or may not be referred by a physician, and more than half are referred back to their private physicians as needing medical and surgical care.

"The interest of the public in some method of early detection of cancer is attested by the phe-

nomenal growth of the American Cancer Society during the past year, the calibre of the lay public that have enlisted their services in the movement, and the funds that have been raised for these purposes. The demand is for some method that is different from the past of coping with the problem that will instill new confidence and hope in the public and cause persons to seek early diagnosis. It is the duty of the doctors to see that this public demand is met early in a manner consistent with our professional ethics, before an impatient public embraces methods repugnant to the standards we wish to see preserved.

"RECOMMENDATIONS

"*First:* That basic principles and medical ethics govern the establishment of all types of tumor clinics.

"*Second:* That diagnostic and treatment clinics in hospitals should be established in accordance with standards set by the American College of Surgeons. The question of eligibility of patients and fees to be charged in such clinics to be determined by the sponsoring hospital and staff.

"*Third:* That *detection*, *prevention*, or *well-person* clinics be conducted in accordance with standards set by the American Medical Association and American Cancer Society; that is, a complete history be taken and a complete physical examination be made, but no definite diagnosis or treatment be given and the patient referred to the family physician with recommendations in the light of the examination performed. If x-ray examination, clinical laboratory work, or surgery (biopsy) are indicated, this should be included in the recommendation to the family physician. Eligibility to these clinics includes all persons with or without referral by their family physician, and no fee is to be charged. This type of clinic thus becomes a method for surveying a large number of well persons and would serve as a case-finding procedure.

"*Fourth:* The Committee approves the establishment of clinics as outlined in recommendations two and three, and emphatically disapproves of the State Board of Health or Foundation-sponsored detection, diagnostic or treatment clinics regardless of whether a fee is charged for the service.

"CHESTER A. STAYTON, M.D., *Chairman*,
"A. T. JONES, M.D.,
"A. S. GIORDANO, M.D.*"

"April 13, 1946,

"* See attached minority report.

"APPENDIX

"Attached is a copy of a letter from Dr. D. C. McClelland, Lafayette, Indiana, dated April 3, 1946.

"At the request of Dr. Giordano, a minority report regarding Paragraph 3 of Recommendations, is appended.

"MINORITY REPORT

"Substitute for Paragraph 3.

"That detection, prevention or well-person clinics be conducted in accordance with standards set by the American Medical Association and the American Cancer Society. That is, no definite diagnosis or treatment be given, but the patient referred to the family physician with recommendations in the light of the examination performed. The examination, however, should be complete so as to include flat x-ray of the chest, complete blood count, urine, exclusion test for syphilis, rectal and pelvic examination. No examination less thorough than that will essentially limit consequences unfavorable to the medical profession. Eligibility to these clinics should be restricted to only those who have a written request from the family physician, and the remuneration be based upon the ability of the patient to pay a standard fee determined by those responsible for the establishing of the clinic.

"A. S. GIORDANO, M.D.

" 'THE ARNETT-CROCKETT CLINIC
308-312 NORTH EIGHTH STREET
LAFAYETTE, INDIANA

" 'April 3, 1946.

" 'Chester A. Stayton, M.D.,
313 Hume Mansur Building,
Indianapolis 4, Indiana.

" 'Dear Doctor Stayton:

" 'Replying to your letter of March 23, I can give the following information regarding our Detection Cancer Clinic, which was held here February 28.

" 'We planned for it by inserting publicity at intervals during the preceding month in the daily newspaper. The inserts were all audited by me and were in the form mostly of clippings from some of the Women's Field Army literature.

" 'Appointments were made for the examination through the local chairman. The idea behind the clinic had been explained previously at a meeting of the county medical society.

" 'The clinic was held in the St. Elizabeth Hospital with plans for three patients to be taken on every fifteen minutes from 1:30 until 4:30. Three members of the county medical society were selected to make the examinations. All three were very capable men, not practicing in any specialty. A resident was also selected for the purpose of taking histories. None of the physicians was a member of the county medical society cancer committee. A fee of $25.00 was charged for the services of each of the physicians and a per-hour fee was charged for the services of a number of nurses, who assisted, and a stenographer was employed and paid on an hourly basis. These fees have been paid by the Women's Field Army.

" 'Thirty-some appointments had been made and twenty-five people appeared. They were given fairly complete examinations, which included oral, breasts, abdominal palpation and rectal and vaginal examinations. Those who attended were by no means indigents, but people who had an interest in themselves. None had been attended previously

for the complaints given in their histories. All seemed very well satisfied with the examination.

" 'We do not feel that patients should be referred to this type of clinic by their physicians, and we do not feel that a fee should be charged. Reports of the examination were sent to the physician of choice named by the patient.

" 'We believe that the clinic served a useful purpose in that we believe it will cause people to see their own physicians when suspicious symptoms arise. This will be accomplished, we believe, both through the newspaper publicity and conversation disseminated by those who attended.

" 'Very truly yours,

" 'D. C. McClelland, M.D.' "

Dr. Mitchell: What shall we do with this report?

Dr. Clark: I move that we accept the report in its majority. (Seconded by Dr. Clauser.)

Dr. Hauss: May I discuss the motion? I am heartily in favor of all the recommendations. I do think we should go a little further, and that definitely the State Medical Association should sponsor and manage this program. It should not just be left in the hands of the County Societies and it should not be left entirely in the hands of the Cancer Society. That is a lay organization. More and more we are placing these things in lay hands, allowing the lay organizations to take the lead in strictly medical affairs. I definitely feel that the Medical Association should adopt a program that would take more responsibility in preventive medicine. Whenever anything is done like this, it is a lay Cancer Society, or the State Board of Health, or it is something else, other than the actual men in the practice of medicine. I believe we should be a part of the program, and I believe that whenever these clinics are opened up, they should be definitely advertised as being promoted by the Indiana State Medical Association and the Cancer Society.

Dr. Nafe: May I ask, does this mean that the Council approves the establishment of these clinics? I raise that point because we had a meeting the other night in Indianapolis and our local society didn't think well of having these so-called detection clinics. I wonder what your interpretation of the motion is. Does this Council endorse these detection clinics?

Dr. Clark: I simply mean that if we are going to have them, this is the way to do it. I don't want a patient sent into a clinic and charged a fee. I agree, certainly, with the fact that no matter how thoroughly you examine a patient you can't tell him he does or does not have cancer. That is the reason the whole thing is silly, but they are going to have it, one way or another, and the public is demanding some sort of evidence, as Dr. Hauss says, of activity on the part of the society, to show that they are interested in the problem. I think the information they will get in these clinics will mislead some of them; on the other hand, it may do some good.

Dr. Hauss: As I understand this report, there is no information given the patient. It is sent to the doctor.

Dr. Dodds: I feel a little bit like Dr. Nafe does in connection with this problem, and I think in Dr. McClelland's letter, the whole thing depends really on the sentence in the last paragraph, when he says it will cause people to see their own physicians when suspicious symptoms arise. I don't believe, with a cursory examination such as has been recommended here, that you can assure someone that he doesn't have cancer, and I think we are treading on dangerous ground when we lead the public to believe that such a cursory examination as this will exclude cancer. My father had a thorough examination, and two or three months later had inoperable carcinoma, and I don't believe it a safe thing to do just to send a person through a well-person clinic and reassure him.

Dr. Clark: He is sent back to his doctor.

Dr. Dodds: If he has no symptoms?

Dr. Clark: He is not told yes or no; he is sent back to his doctor.

Dr. Sparks: We allow ourselves to be high-pressured into a lot of things. I agree with everything the men have said about the public demanding certain things from us. We have had discussions on annual medical examinations for a good many years, and if that phase is pushed, and people come to their physicians for regular examinations, there won't be any need for clinics, for detection of anything. Any abnormalities would be found in the course of the annual examination. That is the answer, I think, to the public demand that comes up, but how to bring that about is the problem.

Dr. Howard: I think the whole thing is this: these people have a lot of money and they want to spend it. We are about to solve the problem in our County by spending it for them. They have agreed tentatively to turn over a portion of their money, together with a lot of the T. B. money, and our County Society is going to spend it in an educational program that we will devise.

Dr. Mitchell: Question. All in favor of accepting this report, say "Aye."

Dr. Sparks: One question which came up and hasn't been made clear. Are we recommending that these clinics be established?

Dr. Stayton: No.

Dr. Clark: We are saying what type of clinic is established if one is established.

Dr. Stayton: Yes. If Marion County doesn't want a clinic, they don't have to have it.

Dr. Sparks: We are on record as favoring the establishment of a clinic?

Dr. Clark: No, we are favoring a given type of clinic, subsequent to the County Society, if they want a clinic.

(Motion carried.)

3. *Report on Mutual Medical Insurance, Inc.*

DR. KENNEDY: As this body will constitute the insurance society, we will leave a report on it until we convene this afternoon.*

Luncheon

Discussion of unfinished business was continued during luncheon.

4. *Report of Building Committee.*

DR. PAUL A. GARBER, *Chairman:* What little I have to say is informative. The president appointed a committee, consisting of Minor Miller, of Evansville, O. A. Province, of Franklin, and myself, on the State Building Committee. We had a meeting in January with the Indianapolis committee, and discussed the feasibility of the State Society joining with the Indianapolis Society and helping with the building, and being able, so far as the State Association is concerned, to house our State Headquarters, our JOURNAL, and we could have a building where we could meet. We saw a tentative plan of such a building. In that building would be incorporated, of course, committee rooms and things like that, and an auditorium capable of seating approximately 500 individuals. Then we came down to a discussion on what proportion of the cost of the building should the State Association probably bear, and for your approval we felt that probably one-third of the construction costs, and one-third of maintenance cost should be borne by the State Association, and that the cost of erecting such a building should be held down to $250,000 to $300,000. That is about as far as we have been able to go. There has been no site selected. There has been a movement on foot to get a site at the Medical Center. A lot of us feel that the building should not be near the Medical Center, but should be near our downtown business section, particularly in the neighborhood of where we hold our State Association meetings when we meet in Indianapolis.

I would like to suggest that if this committee is to continue to function, I think it would be well to have a couple of additional members appointed to the committee, representing the Northwestern section of the state, also probably one from the Southeastern section of the state, and maybe the Western section of the state. That is just a suggestion. I think that is about as far as I am able to report on our activities at the present time.

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* Following the insurance company meeting, it is reported that full organization was completed. Officers elected were Dr. W. U. Kennedy, as president, Dr. W. H. Howard, as vice-president, Dr. Walter Portteus, as secretary, and Dr. A. F. Weyerbacher as treasurer.

By-Laws were adopted. A subscriber's contract was adopted carrying not only surgical indemnities but obstetrics and outside hospital injuries and in hospital medical care. A contract with the Blue Cross for selling and collection was approved.

It was announced that when adequate capital was in hand, operations would begin.

DR. CLARK: Is it Dr. Garber's idea that we should take any action on this matter, or is it assumed the committee will continue?

DR. MITCHELL: It is assumed the committee will continue and the president will appoint more members.

DR. ROMBERGER: Has the committee discussed the feasibility of having it in a location where rental space could be rented and an income had?

DR. GARBER: The tentative plans were not for a rental space to be incorporated in the building.

MEMBERSHIP PROBLEMS

1. The membership of a physician in the Twelfth district was discussed but action was deferred pending receipt of a formal request from the physician for membership in the state association.

DR. ROMBERGER: The Council should write a letter of commendation to the County Society, thanking them for their report, and thanking them for the exercising of their right to police their own Society.

(Motion made by Dr. Clark, seconded by Dr. Kennedy, and carried.)

2. *Incorporation of Brown County with Monroe County Medical Society, or Bartholomew County Medical Society.* It was taken by consent that Dr. Overpeck should report on this at the next meeting of the Council.

3. *Merger of Owen and Monroe County Medical Societies into Owen-Monroe Medical Society.* Dr. Mitchell read the folowing communications:

a. *Resolution from the Owen County Medical Society:*

"Spencer, Indiana,
27 February 1946.

"Resolution

WHEREAS:

The counties of Owen and Monroe are adjacent and are both incorporated in the Second Councilor District;

AND WHEREAS:

It would be mutually beneficial for these two medical societies to unite and form one strong society;

AND WHEREAS:

Such merger is provided for under Sec. 8, Chapter VII, By-Laws of the Indiana State Medical Association, which provides as follows:

> 'In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately';

NOW THEREFORE BE IT RESOLVED:

That the Owen County Medical Society petitions the Council of the Indiana State Medical Associa-

tion, thru its Councilor, to approve the merger of the medical societies of Owen and Monroe Counties into a joint society to be known as the Owen-Monroe Medical Society, and requests that such charter be issued at the next regularly scheduled meeting of the Council in April, 1946.

Passed at the February meeting of the Owen County Medical Society held February 27, 1946.

————————, *President,*
JULIA S. THOM, *Secy-Treas.*"

Owen County Medical Society has no president, as President R. H. Richards died in 1945 and no new officers have been elected.—*J.S.T.*

b. *Letter from Monroe County Medical Society, dated February 27, 1946:*

"Dr. James H. Crowder, Councilor,
Second District, I. S. M. A.,
Sullivan, Indiana.
"Dear Doctor Crowder:

"At the February meeting of the Monroe County Medical Society, held in Bloomington on the 27th, the enclosed resolution was unanimously passed. We request that you present and sponsor this resolution, along with an indentical one passed by the Owen County Medical Society, at the next meeting of the Council.

"We believe that such a merger of these two societies will be mutually beneficial.

"Very truly yours,
"A. M. OWEN, M.D., *Secy.-Treas.*"

DR. MITCHELL: Monroe County has the same resolution as the Owen County Society. Is it your pleasure that they be issued a charter designating them as the Owen-Monroe Medical Society?

(Motion made by Dr. Howard, seconded by Dr. Sparks, and carried.)

LEGISLATIVE MATTERS

1. *National.* Mr. Hendricks reported on the status of the Wagner-Murray-Dingell bill.

2. *Local.* Dr. J. William Wright, co-chairman of the Legislative Committee of the state association, spoke briefly on local legislative problems.

3. *Farm problem.* This subject was discussed by Dr. F. S. Crockett, chairman of the Committee on Rural Medical Service of the American Medical Association.

DR. CROCKETT: Briefly, rural medical service is part of the general picture with which we are all struggling, and of which our own prepaid medical plan is a part. The Committee, acting on a national basis, has tried to stimulate the various states to appoint rural medical service committees, and we have one in this state which is quite active. We held a National Conference two weeks ago yesterday, in which thirty states were represented with medical delegates, sixteen farm bureau states were represented, together with national officers of the Farm Bureau, some from the Farmers Union, some from the Grange present. We put on a program presenting diverse views of the government and the farmers. We found the farmers had a medical viewpoint quite in harmony with ours, and in opposition to the viewpoint outlined by the Social Security Administration. In the afternoon we had a round-table discussion by the delegates from the states.

A week ago today the Indiana Committee met with the comparable committee of the Farm Bureau. We had a very interesting meeting here in this building. As a result of that meeting it was determined to try to find somewhere in Indiana a community or county where we could put on a pilot plan, a plan which would be ideal in many ways to meet the general thinking in regard to the farmer-and-doctor relationship and attracting doctors to the rural communities. We realize the problem is economic and social, as well as professional. In any trial plan, provision must be made to make it possible for the doctors in the country to have diagnostic and consulting service equal to that enjoyed by those practicing near an approved hospital. The Medical Profession will have to assume responsibility for that. Briefly, this is the report. We are getting a liberal response from all over the United States in this matter of better rural medical service and hope it will continue.

1946 (97TH) ANNUAL SESSION AT INDIANAPOLIS

DR. BATMAN, *Chairman,* Committee on Convention Arrangements: I think after everybody has been well fed is a good time for me to bring this up. I think you have had the mimeographed sheets with regard to our present convention plans. The Murat Temple is to be made the headquarters for as nearly everything as possible. Secondly, the local committee suggests again that a series of instructional courses to the men in general work be given. This is as was inaugurated in 1943, when I was general chairman, and was again done in 1944, and we believe could be done again here with the facilitites of the Murat Temple. Admission will be charged for these instructional courses, and these charges will bear all the expense of the project as in the past. The annual banquet will be held at the Murat Temple, without a cocktail party. The program following the banquet will be held in the theater, but it is our plan to make admission only through the banquet hall. The usual stag party for men on Tuesday evening, will be arranged. A buffet lunch, together with liquid refreshments will be served. Entertainment for the women will be provided on the same evening. After these parties a show will be given in the theater, at which physicians' wives will be welcome. In regard to sports events, adequate facilities for golf and trap shoot will be available. We believe these should be held and should be so managed as to make them most outstanding.

The budget has to be a good deal larger than in the last few years. Our estimates would indicate that the stag party, at which we confidently expect 1,000, will cost approximately $1.00 a head. The Tuesday evening show is put down at no increase. Provision for some entertainment at the women's banquet has been made. The sports program is an item not present in the budget for the last few years, and a contribution to the physi-

cians' wives' entertainment through the Auxiliary ought to be in order. We put down a nice sum for contingencies. We would like to have at least $3,000.00. We cannot estimate costs very accurately. We hope we can operate well below our budget.

DR. MITCHELL: The Budget Committee has allowed the local committee $1,500.00 for the annual meeting. The Council will have to do something on the financial end of it if they want to increase that over what the Budget Committee has already allowed.

DR. WEYERBACHER: We are within our budget. I think it can be allowed if there is some reason for it.

DR. CLARK: I move that we allow the local Society $3,000.00.

(Motion seconded by Dr. Hauss, and carried.)

NEW BUSINESS

1. *Nominations for Editorial Board.* It was taken by consent that additional nominations for places on the Editorial Board would be made at the July meeting of the Council.

2. *Clarification of Dr. Crowder's term of office as councilor of the Second District.* Dr. Mitchell read the following letter, dated at Bloomington, February 27, 1946:

"The Council,
Indiana State Medical Association,
Indianapolis, Indiana.

"Gentlemen:

"The Monroe County Medical Society respectfully requests a clarification of the term of office of our Councillor, Dr. James H. Crowder of Sullivan.

"It is our understanding that Dr. Crowder was elected, (by drawing his name out of a hat by three representatives of the District at the French Lick Session) to fill the unexpired term of office of Dr. Wadsworth who resigned prior to the last annual meeting. Dr. Wadsworth's term expired Dec. 31, 1945 (see p. viii, Dec. issue *Jr. Ind. State Med. Assn.*)

"Support of this fact is found on p. 554 of the December issue of THE JOURNAL, which states:

> 'THE PRESIDENT—Inasmuch as this entails the appointment of a new councilor to finish out Dr. Wadsworth's term . . .'

"We feel that Dr. Crowder should serve only until the Second Councilor District can meet and properly elect Dr. Wadsworth's successor, and we question the validity of Dr. Crowder's term expiring Dec. 31, 1948, as carried in current issues of THE JOURNAL.

"Very truly yours,
"A. M. OWEN, M.D., *Secy.-Treas.*"

MR. STUMP: Woudn't it clear the problem if this Council merely adopted a motion to the effect that it is the consensus of opinion of the Council that the present Councilor shall continue until the next meeting of the Councilor District, at which time the district society should elect a permanent Councilor for the term?

(Dr. Sparks made a motion to that effect; Dr. Kennedy seconded it, and the motion carried.)

3. *July meeting of Council.* It was taken by consent that the next meeting of the Council shall be held on July 21, at 10:30 A. M., Indianapolis time.

There being no further business, the meeting adjourned at 2:00 P. M.

THOMAS A. HENDRICKS,
Executive Secretary.

EXECUTIVE COMMITTEE

April 13, 1946.

Roll call showed the following present: Cleon A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. M. Mitchell, M.D.; E. M. Shanklin, M.D.; A. F. Weyerbacher, M.D.; Albert Stump, attorney; Thomas A. Hendricks, executive secretary, and Ray E. Smith, assistant executive secretary.

Guest: L. E. Burney, M.D., secretary, State Board of Health.

Membership Report

Number of members March 31, 1946	3,106*
Number of members March 31, 1945	2,681
Gain over last year	425
Number of members April 12, 1946	3,163
Number of members Dec. 31, 1945	3,396

* Includes 312 veterans, 754 in military service and 145 honorary members.

Treasurer's Office

Loans to veterans. Dr. Weyerbacher reported that applications had been received from three veterans for loans. One loan has been granted, one is pending, and one was refused because the applicant is not a member of the association.

Actions to Be Taken as Result of 1945 House of Delegates Meeting

The president of the association is to confer with the presidents of the State Bar and State Dental Associations at a date to be set sometime later.

Constitution Committee. Dr. Ferrell asked members of the Executive Committee for suggestions for personnel of the Constitution Committee, saying he wished to make the appointments in the near future. (Since the Executive Committee met, the following members have been appointed to serve on this committee: A. W. Cavins, George V. Cring, Cleon A. Nafe, E. L. Libbert, and O. E. Wilson.)

Administrative chart. The executive secretary reported that this is being worked on.

Statements of receipts and expenditures for February and March for the association committees and THE JOURNAL were approved.

1946 Annual Session, Indianapolis, Oct. 29, 30, 31, 1946

Dr. Gordon Batman has been appointed chairman of the Committee on Convention arrangements.

Scientific exhibit. The Executive Committee agreed by common consent that Dr. C. G. Culbertson should be asked to serve as chairman of this

committee and that he should be permitted to select the members of his committee.

Instructional courses. Instructional courses will be held again this year. Dr. Russell Sage is chairman of this committee.

Scientific program. The Committee on Industrial Health wishes to sponsor a scientific meeting during the annual session. This matter was referred to the Scientific Work Committee.

Motion pictures. Request received from a commercial exhibitor for permission to show sound motion picture on "Skin Studies." The Executive Committee saw no objection but referred this matter to the Committee on Scientific Work.

Legislative, Legal and Social Security Matters

National

Wagner-Murray-Dingell bill.

a. The executive secretary reported that hearings were proceeding on this bill, with an indication that the bill would not be passed by this Congress.

b. *Outcome of Y. W. C. A. conference.* The executive secretary said that the resolution endorsing the Wagner-Murray-Dingell program had not been presented and gave credit to the Woman's Auxiliary for helping prevent presentation of this resolution before the conference.

c. The assistant executive secretary gave a review of a resolution adopted by the Lake County Medical Society in which members declared their unwillingness to participate in the federal compulsory health program.

Prepayment Medical Care

Mutual Medical Insurance, Inc. Albert Stump reported on the progress of the company. The adoption of the form of contract is the next step, and this was to be presented to the Board of Directors of the company for approval at its meeting on April 14.

National plan setup. The executive secretary reported that Jay Ketchum has been appointed director of the Division of Prepayment Medical Plan of the Council on Medical Service and Public Relations of the American Medical Association.

Organization Matters

County Health Council. Letter received and read to the committee from a member of the Bartholomew County Medical Society saying that that society is organizing a health council within that county.

Membership in Hoosier State Press Association. On motion of Dr. Mitchell, seconded by Dr. McCaskey, the executive secretary was instructed to take out an associate membership in the Hoosier State Press Association, at a cost of $12.50 per annum.

Membership in Indiana Social Welfare Conference. The committee decided to continue membership in the Indiana State Conference on Social Work in the executive secretary's name, at $10.00 per year.

State Board of Health

Dental clinic. The state health commissioner explained in detail the dental clinic being established at Richmond, Indiana.

Rural Health

The assistant executive secretary gave a report on a joint meeting of the Committee on Rural Health and a like committee appointed by the Indiana Farm Bureau, Inc.

Venereal Disease Committee

Report of the Committee on Venereal Disease, as prepared by Dr. F. R. N. Carter, was presented to the committee.

Future Medical Meetings

A. M. A. meeting, San Francisco, July 1 to 5, 1946. On motion of Dr. McCaskey, seconded by Dr. Romberger, the executive secretary was instructed to attend the A. M. A. meeting in San Francisco.

Ohio State Medical Association meeting, May 7, 8 and 9, 1946. Dr. Charles N. Combs, chairman of the Centennial Celebration Committee, and the assistant executive secretary were authorized to attend this meeting.

There being no further business, the meeting was adjourned.

BUREAU OF PUBLICITY

April 1, 1946.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, assistant executive secretary and secretary of the bureau.

The following news releases for "Hints on Health" were approved:

Week of April 8, 1946—"Milk Is a Valuable Food."

Week of April 15, 1946—"Whooping Cough."

The following news releases for daily papers were approved:

"Diet and Old Age."

"Arteries and Old Age."

Reports on medical meetings:

March, 26, 1946—Lions Club, Pendleton. "Socialized Medicine."

March 26, 1946—Allen County Medical Auxiliary, Fort Wayne. "Health Insurance."

BUREAU OF PUBLICITY

April 15, 1946.

Present: H. G. Hamer, M.D., chairman; Thomas A. Hendricks, executive secretary; Ray E. Smith, assistant executive secretary and secretary of the bureau, and Mrs. Lotys Benning Stewart, publicity and radio script writer.

The following news releases for daily newspapers were approved:

"Child Health Day," for release Monday, April 29, 1946.

(Continued on page xxx)

Experience
has no substitute

In
Professional Protection
as in everything else
"knowing" comes from "doing"

With
the successful handling
of more than 60,000 malpractice claims
The Medical Protective Company
brings to its policyholders
Experience
which has no substitute

★

OUR DIRECTORS
have been actively and exclusively engaged in the administration of this protective service for the professions since the years indicated.

B. H. Somers, Pres.—1903

J. W. Brown	1922	G. R. Kirkup	1913
L. M. Ford	1923	F. E. McLucas	1918
L. L. Frank	1910	Dr. W. E. Neuenschwander	1928
H. W. Ginty	1911	B. H. Smith	1923
T. E. Haberkorn	1922	F. G. Somers	1928

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

(Continued from page 330)

"Fitness at Fifty," for release Monday, May 6, 1946.

The following releases for "Hints on Health" for weekly papers were approved:

"If Well, Keep Well!"—week of April 22, 1946.

"Worry Causes Insomnia,"—week of April 29, 1946.

The radio script writer presented the titles of "Ladies, Your Health" radio program for April, as follows:

April 1—"Now That Your Service Man Is Home."

April 8—"Public Health Nursing."

April 15—"Fitness After Forty."

April 22—"Care of the Teeth."

April 29—"Child Health Day."

The secretary was instructed to notify the chairman of the Program Committee of the Woman's Auxiliary of the Indiana State Medical Association that suggested program material for 1946-47 would be submitted. The secretary is to have such a program in order for the bureau's consideration at its next meeting.

The bureau decided to discontinue the weekly radio program, "Ladies, Your Health," at the end of May, and to substitute records from the American Medical Association for the fifteen-minute period. The executive secretary was directed to contact the manager of Radio Station WFBM to see if the recordings would be acceptable.

A leave of absence was granted the publicity and radio script writer for the period of May 31, 1946, to September 1, 1946. Continuation of the radio and news release program is to be taken up and decided at that time.

COUNTY SOCIETY OFFICERS

FOUNTAIN-WARREN COUNTY MEDICAL SOCIETY
President, Hubert M. Rusk, Wallace.
Vice-president, Lee J. Maris, Attica.
Secretary-treasurer, Alvin R. Kerr, Attica.

LA GRANGE COUNTY MEDICAL SOCIETY
President, Clarence H. Schulz, La Grange.
Secretary, Alfred A. Wade, Howe.

POSEY COUNTY MEDICAL SOCIETY
President, John W. Herr, Mount Vernon.
Vice-president, L. John Vogel, Mount Vernon.
Secretary-treasurer, J. R. Ranes, Mount Vernon.

SCOTT COUNTY MEDICAL SOCIETY
President, Marvin L. McClain, Scottsburg.
Secretary, J. P. Wilson, Scottsburg.

LOCAL SOCIETY REPORTS

Dearborn-Ohio County Medical Society members held their annual meeting at the Dearborn Country Club, in Aurora, on April twenty-fifth. The guest speaker was Judge Charles A. Lowe, of Lawrenceburg, who spoke on "Our Changing Times." Twenty-seven members and guests were present at the meeting, which was the first guest dinner meeting held since 1941.

Delaware-Blackford County Medical Society members held a meeting on April sixteenth, at Hotel Roberts. The speaker at this meeting was Dr. Kemper N. Venis, of Muncie, whose topic was "Anesthesia in an Evacuation Hospital." Twenty-five members were present.

Elkhart County Medical Society members met at Hotel Elkhart, in Elkhart, on May second. The forty-three members present heard Dr. Walter G. Maddock, of Chicago, Illinois, discuss the subject "Some Thoughts on Water and Salt in Surgery."

Fort Wayne (Allen County) Medical Society members held a joint dinner and party with the Woman's Auxiliary for returned service men and their wives, on April second, at the Fort Wayne Country Club. One hundred forty-five members and guests attended.

On April sixteenth a regular meeting was held, at the Chamber of Commerce, in Fort Wayne, when a motion picture on "Surgery of Rectal Cancer" was shown. Approximately fifty members were present.

Hamilton County Medical Society members were served dinner by the ladies of the Cicero Methodist Church at the regular monthly session held April ninth at the church. The guest speaker for this meeting was Dr. John Hendricks, of Indianapolis.

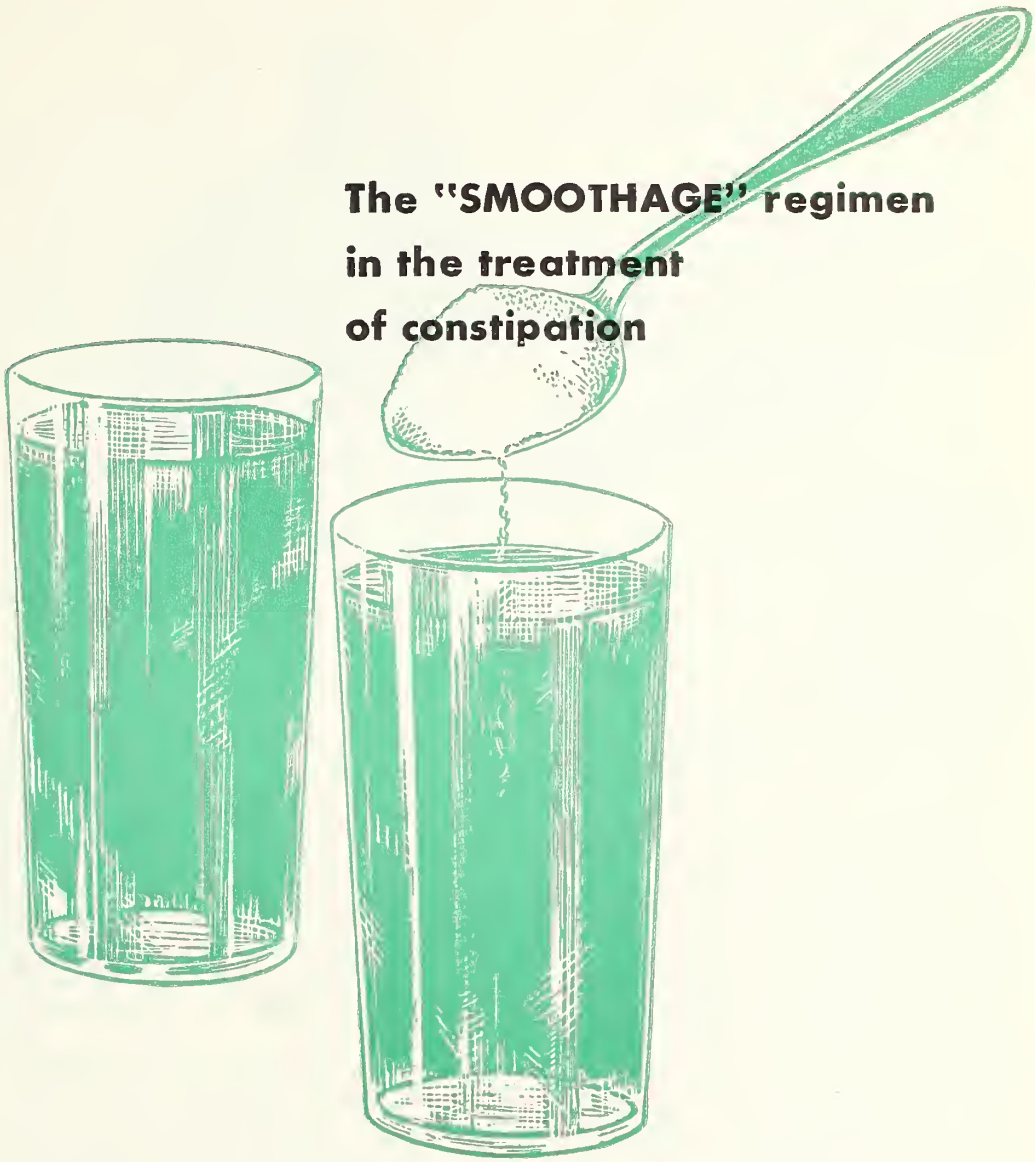
Howard County Medical Society members held a meeting May second, at the Frances Hotel, in Kokomo. Twenty-one members attended, and heard Dr. J. D. Peirce, of Indianapolis, speak on "Recent Advances in Hypertension."

Indianapolis (Marion County) Medical Society members met at the Nurses' Home at St. Vincent's Hospital, in Indianapolis, on May fourteenth. Speakers were: Dr. Roy V. Myers, of Indianapolis, whose subject was "Agranulocytosis"; Dr. John Hendricks, of Indianapolis, who spoke on "Vesicovaginal Fistula"; Dr. P. E. McCown, of Indianapolis, who discussed "Priapism," with a case report of Malignant Priapism; Dr. M. L. Ruth, of Indianapolis, whose choice of a subject was "Allergy in Reference to Sinusitis and Migraine."

At their meeting on May twenty-first, the program was sponsored by the Eli Lilly Laboratory for Clinical Research. Speakers and their subjects were: "Present Concepts of the Etiology of Hypertension," by Drs. O. M. Helmer and R. E. Shipley; "Treatment of Essential Hypertension with Potassium Thiocyanate," by Dr. James D. Peirce; "Recent Advancements in Digitalis Therapy," by Dr. Kenneth G. Kohlsteadt.

At another meeting, on May twenty-eighth, Dr. Kenneth L. Craft, of Indianapolis, discussed "Nasal Allergy"; Dr. Russell W. Lamb spoke on "Surgical Treatment of Undescended Testicle," (With Clinical Demonstration); and Dr. A. J. Micheli discussed "Classification of Solid Tumors of the Ovary."

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Parke-Vermillion County Medical Society members met at the Vermillion County Hospital, at Clinton, on April twenty-fourth. Dr. W. D. Gerrish was the speaker of the evening, choosing "Atypical Pneumonia" as his subject. Eight members attended the meeting.

LaPorte County Medical Society members held a meeting at the Rumley Hotel, in LaPorte, on April twenty-first. The twenty-two members present heard a discussion of "Neurology and General Medicine," by Dr. Robert L. Glass, of Indianapolis, the guest speaker for this meeting.

Warrick County Medical Society members held a meeting on March twelfth at the Legion Home, in Boonville, at which time Dr. Pierce MacKenzie, of Evansville, presented a paper on "Breech Extractions and Newer Developments in Obstetrics." Ten members attended the meeting.

On April tenth, the members again met at the Legion Home to hear a discussion of "Renal Calculi" by Dr. Robert Acre, of Evansville. Eight members were present at this meeting.

COUNCILOR DISTRICT MEETINGS

ELEVENTH COUNCILOR DISTRICT

Dr. Max R. Adams, of Flora, was elected president of the Eleventh Indiana Councilor District at the seventy-fifth semi-annual meeting held at Peru on May 15. Dr. O. G. Brubaker, of North Manchester, was re-elected secretary-treasurer.

Marion was selected as the place for the fall meeting. Wednesday, September 18, was the date chosen.

Five physicians who were present thirty-seven and a half years ago when the district was organized at Peru were in attendance on May 15. They were Drs. George R. Daniels, of Marion; John E. Yarling and David C. Ridenour, both of Peru; N. H. Thompson, of Wabash; and Joseph A. Meiner, of Kokomo.

The district voted to invest $250 of its funds in the Mutual Medical Insurance, Inc., after the purpose of the company was explained by Dr. Jesse E. Ferrell, of Fortville, president of the Indiana State Medical Association, and Albert Stump of Indianapolis, counsel for the association. Ray E. Smith, executive secretary of the association, was another guest speaker.

The scientific program consisted of the following: "Anesthesia," by Dr. John M. Whitehead, of Indianapolis; "Contact Dermatoses," by Dr. Louis Spolyar, of Indianapolis; and "Varicose Veins," by Dr. Russell W. Lamb, of Indianapolis.

The meeting closed with a banquet in the Presbyterian Church. Rev. Robert Hall, of Michigan City, chaplain of the Indiana State Prison, was the principal speaker.

TWELFTH COUNCILOR DISTRICT

The annual meeting of the Twelfth Councilor District of the Indiana State Medical Association was held at the Fort Wayne Athletic Club, in Fort Wayne, on the afternoon and evening of April thirtieth. There were one hundred fifteen registrations. Dr. Lyman Meiks, of Indianapolis, presented a paper on "Pneumonia in Children," followed by Dr. Chauncey C. Maher, of Chicago, who spoke on "Cardiac Decompensation with Edema." At the business meeting, which followed, officers were elected, and after dinner Dr. Lester Dragstedt, of Chicago, gave an illustrated talk on "Resection of Vagus Nerves for Peptic Ulcer."

WOMAN'S AUXILIARY to the Indiana State Medical Association

President.....Mrs. F. M. Gastineau, Indianapolis
President-elect.....Mrs. S. J. Petronella, East Chicago
Corresponding Secretary.....Mrs. C. L. Bock, Indianapolis
Treasurer.....Mrs. A. W. Ratcliffe, Evansville
Press and Publicity.....Mrs. A. B. Richter, Indianapolis

Mrs. F. M. Gastineau, of Indianapolis, the retiring president of the Woman's Auxiliary to the Indiana State Medical Association, entertained thirty-seven members of the Board of Directors, chairmen of standing committees, county presidents, and presidents-elect at a buffet dinner in her home, 5344 North Pennsylvania Street, as the opening to the Second Annual Meeting of the House of Delegates, on Wednesday evening, April twenty-fourth.

At this meeting revisions to the constitution were discussed and suggestions offered for the meeting to be held in the fall.

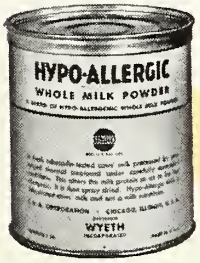
The following day the House of Delegates convened at the Columbia Club at 10:00 A.M. Mrs. F. M. Gastineau presided. Mr. Ray Smith, Executive Secretary of the Indiana State Medical Association, extended greetings to the auxiliary and offered his services whenever needed.

Dr. Walter U. Kennedy, of New Castle, spoke at the meeting and explained that the Indiana State Medical Association will combat socialized medicine by the creation of an insurance company, controlled and operated by doctors. This company, to be known as Mutual Medical Care, Inc., will be operated non-profit, with costs as low as may be charged with safety, with the good of the people as its sole aim, and with the honor of the medical profession as a guaranty of honesty of operation. Dr. Kennedy explained that the company will be closely associated with the Blue Cross hospitalization plan. Dr. Kennedy is the president of the new organization. The company will be in operation within a month and has assurance of support from industrial organizations.



Protein a problem?

Altered Protein

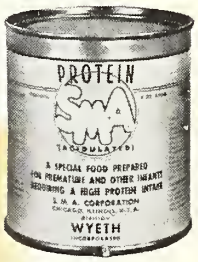


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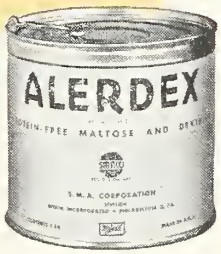
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S. M. A. DIVISION

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HIGH LIGHTS OF BUSINESS SESSION

1. The meeting showed an increased attendance over last year, having seventy-three members and two guests present, which shows that the new plan of organization is very successful.

2. Treasurer's report: Balance on hand April 24, 1946, $1,140.11. Mrs. A. W. Ratcliffe, Treasurer.

3. Membership: One Thousand and nineteen members, showing an increase of seventy-two members, with sixty members at large.

4. *Hygeia:* (a) Mrs. O. H. Bakemeier reported Indiana as having gone over its quota by forty-seven subscriptions, and a gain over last year of two hundred fifty-seven subscriptions. (b) Honorable mention was given Cass, St. Joseph, Vanderburgh, and Vigo counties for having exceeded their quotas. (c) Counties bringing their quotas up to nearly 100 per cent were Clark, Tippecanoe, Porter, and Wells. (d) Our subscriptions have increased 365 per cent in two years.

Revisions to the Constitution were presented by Mrs. Charles Voyles, parliamentarian, to be acted on at the fall meeting.

The following candidates were submitted by Mrs. James Baxter, nominating committee chairman, and were elected:

President-elect.....Mrs. A. W. Ratcliffe, Evansville
First Vice-President.....Mrs. C. E. Munk, Kendallville
Second Vice-President.....Mrs. C. L. Wise, Camden
Third Vice-President.....Mrs. Arthur Richter, Indianapolis
Fourth Vice-President.....Mrs. Morton Wolfe, New Albany
Treasurer.....Mrs. Wendell Kelly, Anderson
Recording Secretary.....Mrs. M. E. Allen, Greenfield
Corresponding Secretary....Mrs. David A. Eisenberg, Hammond

Installation of the new officers, with Mrs. S. J. Petronella, of East Chicago, as president, was conducted by Mrs. Charles Voyles, auxiliary parliamentarian.

Mrs. Petronella announced the appointment of the following chairmen for the year:

Mrs. J. E. Ferrell, Fortville, Archives; Mrs. Milton Gevirtz, Hammond, *Bulletin;* Mrs. C. W. Dahling, New Haven, War Service; Mrs. R. Palmer, Gary, *Hygeia;* Mrs. Lester A. Smith, Indianapolis, Legislation; Mrs. O. H. Bakemeier, Indianapolis, Press and Publicity; Mrs. D. E. Lybrook, Galveston, Program; Mrs. Charles F. Voyles, Indianapolis, Parliamentarian; Mrs. F. S. Cuthbert, Kokomo, Historian; and Mrs. A. J. VanWinkle, Valparaiso, Physical Fitness.

A short Board of Directors meeting was held with Mrs. S. J. Petronella presiding and plans for the fall meeting were discussed.

ALLEN COUNTY

The members of the Woman's Auxiliary to the Allen County Medical Society were special guests at the annual meeting of the Fort Wayne Art Association, held at the Fort Wayne Art School and Museum on Tuesday night, April ninth. Franklin Boggs, noted artist who has done special war paintings in the Pacific area for the Abbott Laboratories, was the guest speaker.

MARION COUNTY

The Woman's Auxiliary to the Indianapolis (Marion County) Medical Society held its annual May luncheon-bridge and election of officers at the Meridian Hills Country Club, on Tuesday, May ninth, with one hundred thirty in attendance. The following officers were elected:

President-elect.....Mrs. Otto H. Bakemeier
First Vice-President.....Mrs. Reid L. Keenan
Second Vice-President.....Mrs. Paul Fouts
Third Vice-President.....Mrs. A. B. Richter
Treasurer.....Mrs. E. W. Dyar
Recording Secretary.....Mrs. Clifford C. Taylor
Corresponding Secretary.....Mrs. Burleigh Matthews
Historian.....Mrs. Foster Hudson
Parliamentarian.....Mrs. Charles F. Voyles
Publicity.....Mrs. Gail Eldridge

Mrs. Emmett Lamb is the new president.

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—April, 1946

Diseases	*Apr. 1946*	*Mar. 1946*	*Feb. 1946*	*Apr. 1945*	*Apr. 1944*
Chickenpox	327	529	273	257	592
Measles	2948	4371	1150	106	1185
Scarlet Fever	359	517	449	451	972
Smallpox	2	5	2	7	2
Typhoid Fever	7	4	4	10	6
Whooping Cough	106	109	80	43	49
Diphtheria	41	57	71	16	23
Influenza	57	74	200	4	24
Pneumonia	20	35	35	11	27
Mumps	183	191	90	280	268
Poliomyelitis	1	3	1	.....	1
Cerebrospinal Meningitis	15	13	14	14	38
Undulant Fever	2	9	3	4	6
Septic Sore Throat	17	42	10	8	25
Erysipelas	4	2	2	3	1
Tularemia	1	2	5	.....	.....
Malaria—Acq. Outside U. S.	26	53	10	1	4*
Malaria—Acq. Inside U. S.	1	1	.....	.....	..... *
Infectious Jaundice	4	4	1	3	.....
Rubella	60	30	5	8	29
Unclassified Dysentery	1	1	.....	.....	27
Amebic Dysentery	1	.....	.....	.....	.....
Tetanus	2	.....	.....	1	.....
Impetigo	2	7	8	3	.....
Ringworm of the Scalp	304	12	.....	.....	.....
Conjunctivitis	2	1	1	.....	2
Tuberculosis, Pulmonary	206	262	163	259	255
Tuberculosis, Other forms	14	12	12	7	3

* Not stated as to whether the disease was acquired outside or inside United States.

HEALTH IN PLUS FOURS

The health department often mails form letters to delinquent venereal disease patients, stressing the importance of continuing their treatments. A darky's reply to one of our reminders reads as follows: "You says in your letter that I have a Venral Disease, but I does not and has never had one. The only thing my doctor ever says I had was Cyphlis and I aint never felt bad from that yet. My doctor tole me, too, that my blood was plus four and my blood pressure high so you see I am O.K. and dont need no shots."

—*Readers Digest.*

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Books

BOOKS RECEIVED

MODERN TRENDS IN CHILD PSYCHIATRY. Edited by Nolan D. C. Lewis, M.D., and Bernard L. Pacella, M.D. 341 pages. Price $6.00. Cloth. International Universities Press, New York, 1945.

REVIEWED

A MALARIOLOGIST IN MANY LANDS. By Marshall A. Barber. 158 pages with several illustrations. Cloth. Price $2.50. University of Kansas Press, Lawrence, Kansas, 1946.

Because of the war, malaria, always a serious public-health problem, is a timely and important topic. This book, however, is not technical; the lively and informal story of the author's travels and experiences contains a great deal of general human interest. A significant aspect of the book is the way in which it demonstrates how the prevalence of malaria is related to environmental factors, such as floods, famine, irrigation, and the presence of wild animals.

UNHAPPY MARRIAGE AND DIVORCE. Edmund Bergler, M.D. 167 pages. Cloth. Price $2.50. International Universities Press, New York City, 1946.

Dr. Bergler's theory regarding the cause of marital maladjustments is that the roots of marital failure reach far back into the childhood of the persons involved, when a pattern of neurotic behavior was unconsciously established. The scientific discussions are illustrated by case histories, and the book affords a new insight into problems pertaining to marriage.

SYNOPSIS OF PHYSIOLOGY. By Rolland J. Main, Ph.D., Professor of Physiology, Medical College of Virginia, Richmond. 341 pages with 21 illustrations. Fabrikoid. Price $3.50. The C. V. Mosby Company, St. Louis, 1946.

This is a small book, designed especially as a review or refresher volume, covering the high spots of physiology, providing adequate fundamental material, and incorporating advances in the subject.

Brief mention of some physiologic disturbances is made to emphasize the contrast of normal and abnormal. Relative space devoted to the various subjects is determined by their complexity, clinical interest and importance, and recency.

THE PRINCIPLES AND PRACTICE OF MEDICINE. Fifteenth edition. By Henry A. Christian, M.D., Hersey Professor of the Theory and Practice of Physics, Emeritus, Harvard University; Clinical Professor of Medicine, Tufts College Medical School. (This book was originally written by Sir William Osler, Bart, M.D., and was designed for the use of practitioners and students of medicine.) 1498 pages. Cloth. Price $9.50. D. Appleton-Century Company, Incorporated, New York, 1944.

This is the Fourteenth and Semi-Centennial (1892-1942) Edition. After fifty years, it retains the same general arrangement. Many of the descriptive phrases, and even whole chapters, remain as originally written in the ageless and inimitable style of Osler. It has been rewritten now at a time when there is an urgent need for the newer knowledge of tropical diseases. It also brings up to the copyright date the latest advances in chemotherapy and the use of antibiotics. It is a perennial standard textbook required for every library.

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INDIANA STATE BOARD OF HEALTH

MORBIDITY REPORT FOR THE YEAR 1945 BY COUNTIES BY MONTHS

Diseases	*Jan.*	*Feb.*	*March*	*April*	*May*	*June*	*July*	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*	*Total*
Chickenpox	563	480	529	257	219	162	55	20	34	82	159	300	**2860**
Measles	27	49	142	106	157	145	39	22	16	17	18	40	**778**
Scarlet Fever	521	717	782	451	403	219	77	52	87	217	260	292	**4078**
Smallpox	6	6	10	7	10	1	1	0	0	1	4	4	**50**
Typhoid Fever	4	2	10	10	3	10	6	5	17	6	7	2	**82**
Whooping Cough	54	73	60	43	72	103	127	135	87	113	105	92	**1064**
Diphtheria	24	33	39	16	17	24	14	17	31	55	62	50	**382**
Influenza	28	39	54	4	26	23	6	17	12	26	410	4290	**4935**
Pneumonia	13	13	23	11	9	6	0	1	7	11	9	30	**133**
Mumps	220	278	456	280	237	186	58	37	30	22	47	30	**1881**
Poliomyelitis	3	1	2	0	4	7	5	43	77	36	13	7	**198**
Epidemic Meningitis	19	12	19	14	12	7	12	5	13	8	12	13	**146**
Nonepidemic Meningitis	0	0	0	1	2	1	0	1	0	2	2	0	**9**
Trachoma	2	4	0	2	1	1	0	0	0	0	0	0	**10**
Tularemia	6	2	0	0	0	1	0	0	0	0	2	0	**11**
Vincent's Angina	1	0	0	0	2	0	0	0	3	1	2	0	**9**
Rubella	4	0	9	8	8	6	4	4	0	5	1	1	**50**
Undulant Fever	11	6	1	4	3	4	7	5	6	4	4	3	**58**
Rocky Mt. Spotted Fever	0	0	0	0	2	6	0	8	0	0	0	0	**16**
Septic Sore Throat	0	10	6	8	1	1	1	8	0	13	13	9	**70**
Rabies in Man	0	0	0	0	0	0	0	0	1	0	1	0	**2**
Encephalitis Lethargic	1	0	0	0	0	0	1	4	6	3	2	0	**17**
Nonintectious Encephalitis	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Dysentery	0	1	0	0	2	1	0	1	16	14	1	1	**37**
Malaria, Acq. Outside U. S.	1	0	2	1	0	3	3	5	8	11	10	4	**48**
Malaria, Acq. Inside U. S.	2	0	0	0	1	0	0	0	0	0	0	0	**3**
Tetanus	1	0	0	1	2	1	0	1	3	1	3	3	**16**
Erysipelas	1	0	1	3	1	2	1	1	3	0	4	1	**18**
Conjunctivitis	0	0	2	0	0	1	0	0	0	1	0	3	**7**
Impetigo	2	2	0	3	2	5	4	3	2	1	13	9	**46**
Infectious Jaundice	0	0	3	3	0	5	2	7	2	1	4	1	**28**
Silicosis	0	0	0	1	0	1	0	0	0	0	0	0	**2**
Paratyphoid	0	0	0	0	0	0	0	0	1	0	1	0	**2**
Food Poisoning	0	0	0	0	0	0	0	0	1	0	1	3	**5**
Filariasis	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Pink Eye	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Ringworm	0	0	0	0	0	0	0	6	3	0	0	0	**9**

ABSTRACT: BENEFITS OF SURGERY FOR CERTAIN TYPES OF HYPERTENSION

Medical science is gradually accumulating more and more evidence to show the effectiveness of surgery for certain types of hypertension or high blood pressure.

Two physicians, writing in the February 23 issue of *The Journal of the American Medical Association,* stated that while surgery seldom brings about a cure for high blood pressure, "it has given remarkable benefit, and prolonged the life of many hypertensive patients."

Max M. Peet, M.D., of Ann Arbor, Michigan, and Emil M. Isberg, M.D., of Miami Beach, Florida, review the results of one thousand five hundred operations at the University of Michigan Hospital, and conclude: "No form of medical therapy has yet been shown to be as efficacious as surgical treatment in arresting the pernicious, progressive character of hypertensive disease, promoting improvement, and increasing the life span."

High blood pressure is one of the most common and most serious conditions that American physicians are required to treat. As a common cause of death—particularly among middle-aged business and professional men—hypertension outranks even cancer and tuberculosis.

The tightening and narrowing of the blood vessels which accompany hypertension seem to start in the kidneys. Apparently this narrowing is brought about by some impulse transmitted over the sympathetic nervous system which regulates the involuntary organs of the body. The treatment, therefore, of hypertension by operation on the sympathetic nervous system is aimed at halting these nerve impulses.

The report of Drs. Peet and Isberg concerns only those cases called "essential hypertension." This term is applied to high blood pressures which cannot be attributed to any known disease.

The physicians stress the fact that surgery is not beneficial in all types of high blood pressure.

"The patient whose hypertensive state has not yet progressed to evident involvement of the heart, cerebral arteries, or kidneys stands an excellent chance for prolonged blood pressure reduction from surgical treatment," the doctors say.

Of the one thousand five hundred patients who received surgical treatment for essential hypertension at the University Hospital, the doctors were able to obtain follow-up data on four hundred thirty-seven through periodic visits and re-examination.

Two hundred and fifty-one patients, or 57.5 per cent, are living five to eleven years after operation. At the end of five postoperative years 64.8 per cent of the entire series was alive.

Fifty-six per cent of all the males have died, while the female mortality was only 30 per cent.

Ninety-five per cent of high blood pressure patients who showed no evidence of cardiac, cerebrovascular or kidney involvement before the operation are living five to eleven years after the surgery was performed.

Approximately one-third of all patients who manifested evidence of organic heart disease, cerebrovascular disease, or impaired kidney function before the operation did not survive the five to eleven-year period.

Fifty-one patients have maintained normal blood pressure levels, and twenty-eight show no evidence whatever of hypertensive disease for this period.



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1. Freed, S. C., and Greenhill, J. P. (1941), J. Clin. Endocrinol., 1:983, December.

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THE JOURNAL

OF THE

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

OFFICE OF PUBLICATION: 1017 Hume Mansur Bldg., INDIANAPOLIS 4, INDIANA

VOLUME 39 JULY, 1946 NUMBER 7

THE TREATMENT OF ANEMIA IN GENERAL PRACTICE*

MARION F. BEARD, M.D.†

LOUISVILLE, KENTUCKY

The intelligent and rational treatment of anemia is based, for the most part, on researches into the mechanism and physiology of the hemopoietic system, which have been done since Minot's announcement in 1926 of the efficacy of liver in treating pernicious anemia. While Johannes Lange, in 1554, published an account of iron deficiency as "The Disease of Virgins," and Addison described pernicious anemia, in 1849; since 1926 the work of hosts of investigators—too numerous to enumerate—have markedly increased our knowledge of the blood-forming organs. Undoubtedly our theories built up in such a short time will be subject to change. We can now establish working hypothesis of the abnormalities of the hemopoietic system and with a great deal of accuracy diagnose and treat disorders of this system. The first prerequisite to accurate therapy is accurate diagnosis; hence, we shall review briefly the physiology of this organ system and attempt to point out the important diagnostic features of the various types of anemia.

The red blood cells have their origin from the endothelial cells lining the capillaries of the bone marrow. These cells are capable, under certain stimuli, of developing into megaloblasts which under the influence of erythrocyte maturation factor go through an orderly progression of development and maturation through the early and late erythroblast and normoblast stages. At the normoblast stage the nucleus is extruded, and soon the reticulocyte loses its reticular material and the adult mature erythrocyte is formed. During this development from the megaloblast, globulin and iron, copper and proteins are interacting in the cytoplasm of the cell to form hemoglobin, and by the time the normoblast level is reached the hemoglobin formation is complete. As the wear and tear of the circulation breaks down the erythrocyte it is engulfed by the phagocytic cells of the reticulo-endothelial system chiefly in the spleen and its component parts are salvaged for re-use in the building of new cells.

It is important to review briefly the metabolism of iron. Iron is taken into the stomach and there in the acid medium of the stomach is ionized and then absorbed, and as soon as the iron reaches the alkaline portion of the duodenum absorption ceases. Only minute amounts of iron are excreted. The absorbed iron is stored in the liver and spleen and other organs, and is transported by the plasma to the bone marrow to enter into the formation of hemoglobin. Copper is necessary, as a catalyst only, in hemoglobin synthesis. The role of Vitamin B and of the amino acids is not thoroughly understood at this time.

The metabolism of erythrocyte maturation factor must also be reviewed briefly. The extrinsic factor in protein food interacts with the intrinsic factor in the stomach to form the erythrocyte maturation factor. This is absorbed through the upper portion of the intestinal tract and is stored in the liver. Ordinarily the normal liver contains approximately 300 units of the erythrocyte maturation factor, available for use in the bone marrow to cause maturation of megaloblasts.

If these fundamental physiological facts are remembered, we can then logically divide the anemias into five groups, in each of which we can, with a fair degree of satisfaction, understand

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the mechanism of production of the anemia and apply appropriate remedies to correct the process.

Iron Deficiencies

Causes: Since there is practically no iron excreted from the body there are only two essential causes of anemia from iron deficiency—blood loss and a deficient iron intake in youngsters whose growth causes an expanding need for iron. Since the female has a slight blood loss with each menstrual period, we would expect this type of anemia to be most common in females during the reproductive period. Experience, I believe, bears this out. Since it sometimes takes years to deplete the iron storehouses, however, this frequently does not appear until somewhat late in the reproductive period. In males, iron deficiency anemia always means blood loss; and in youngsters, especially from six months on, it may mean inadequate iron intake.

A deficiency of iron results in an anemia in which there is a reduction in the red count, but chiefly a defect in hemoglobin synthesis without much disturbance in maturation in the bone marrow, so that the peripheral blood shows a normochromic or slightly microcytic, hypochromic anemia. Platelets and leukocytes are unchanged. The reticulocyte count may be normal or may be slightly increased, reflecting the increased activity of the bone marrow.

The bone marrow usually shows hyperplasia of erythroid elements and slight evidence of maturation arrest at late erythroblast levels, but the most striking finding is the disturbance of hemoglobin formation, as evidenced by the lack of proper hemoglobinization of the erythroid elements.

The proper therapy of this entire group is, of course, iron. From what we now know about the metabolism of iron we can use it much more intelligently. In the first place there is at present no commercial iron preparation for parenteral use which will quickly or adequately raise the level of the iron storehouses. There are some experimental solutions, but so far these are unstable and dangerous to use. Since iron is ionized and absorbed in the ferrous state, the use of the ferrous iron, either sulfate or gluconate, has become almost universal. These give more available iron grain for grain than any other form. The older iron preparations, such as iron ammonium citrate, may be used if a sufficient amount is given to secure results. Even iron filling as used by our predecessors could still be used if we gave enough. The question of the addition of liver extract, Vitamin B, or amino acids to oral iron is an open one. While the work of Whipple and others would suggest that these substances are of value in shortening the time of return to normal of the blood, the only published statistical studies are on dogs. My impression is that they do have some benefit, but until the question has been carefully studied this is only an impression.

Copper seems to be purely catalytic in its action, and since most of our therapeutic iron contains some copper as impurity, the addition of this element is usually not necessary. In youngsters, however, whose response to iron is slow, the addition of copper may be necessary.

Thyroid substance in small amounts may at times be necessary for proper correction of some of these anemias. I am unable to explain its mechanism, but we now have several cases in which a return to normal hemopoietic equilibrium followed the addition of thyroid to the iron.

Finally, we must remember that iron is absorbed only in an acid medium, and if gastric HCL. is low or absent, little if any of our therapeutic iron may be absorbed. I have seen this point work out many times, and gastric analysis should be done on patients who do not respond to iron therapy. If HCL. is deficient, its addition to the iron therapy is frequently followed by a prompt and gratifying therapeutic result.

Erythrocyte Maturation Factor Deficiencies

Anemias resulting from a deficiency of erythrocyte maturation factor may result from a lack of intrinsic factor, in which case we have addisonian anemia. This same anemia may result from deficiency of extrinisic factor in dietary deficiency or dietary faddism. It may result also from disturbance in absorption of erythrocyte maturation factor, and from chronic diarrheas, such as in sprue. It may occasionally result from disturbance in the storehouse, as in chronic liver disease. This is quite rare, however. At times, of course, more than one mechanism may be involved.

A deficiency of erythrocyte maturation factor, because it causes a megaloblastic maturation arrest, results in a peripheral blood that is macrocytic and hyperchromic, and shows marked anisocytosis and poikilocytosis. The platelets and leukocytes are reduced, and the neutrophils are right shifted. Reticulocytes are as a rule reduced or normal, and normoblasts are absent.

The bone marrow shows a marked hyperplasia of erythroid elements, a marked increase in megaloblasts, and a moderate increase in phagocytic elements.

The therapy of erythrocyte maturation factor deficiencies is quite simple. One unit of erythrocyte maturation factor per day will maintain a normal equilibrium since one unit is defined as the amount necessary to maintain an addisonian anemia in a normal equilibrium for one day. There is, however, a great deal more to be said about the use of liver extract than this simple statement. There are available a wide variety of liver extracts for parenteral use containing from one to fifteen units of erythrocyte maturation factor per cc., and at least two oral preparations, one of liver extract and one of dessicated hog stomach, all of which contain erythrocyte maturation factor in adequate quantities. For most cases the parenteral route is to be preferred because of simplicity and economy. There is some controversy as to the relative

merit of the crude or low unit versus the refined or high unit extract. If a really potent extract is used and one unit per day given, it makes little difference whether this is given as a large volume of low unit extract at frequent intervals or as a small volume of high unit extract at infrequent intervals. My routine is to give the patient thirty units for thirty days, plus 200-300 units for storage, divided into smaller doses such as fifteen daily units for ten days, then fifteen units every day for twenty days. If a maintenance dose is indicated as in addisonian anemia after return to normal of the peripheral blood, I give either fifteen units every two weeks or thirty units once a month. This schedule has proved entirely satisfactory in both clinic and private patients.

Hypoplastic Anemias

This group of anemias is called hypoplastic rather than aplastic, since complete aplasia of blood-forming organs is hardly ever present. They are the result of toxic effects on the hemopoietic system. Some of these toxemias are known, such as those caused by benzol, arsenic and radiation. Others are speculative as to their direct etiologic effect; these may be sulfonamides, renal disease, or infections. In some cases no etiology can be determined.

This type of anemia results from a direct hypoplasia, of varying degree, of the blood-forming mechanisms. Because of this the peripheral blood shows a reduction in erythrocytes, which is normocytic and normochromic. In severe cases some microcytosis and anisocytosis and poikilocytosis may be present. The platelets and leukocytes are reduced, the amount of reduction varying with the degree of hypoplasia. Reticulocytes may be normal, but are usually reduced, and normoblasts are absent.

The bone marrow shows a generalized reduction in all elements and an increase in fat. In the milder cases there is usually also an increase in monocytes and plasma cells.

The therapy of this group of anemias is more difficult and less specific than in the preceeding two types. In the milder cases we have obtained good results in a number of cases by the use of crude liver extract, the one or two unit erythrocyte maturation factor per cc. kind, one cc. two or three times a week. We give this not for the erythrocyte maturation factor in this case, but for the liver extract and possibly the B complex filtrate factors. In a few cases a small amount of thyroid, ½ to 1 grain per day, has speeded the return of the equilibrium. The whole Vitamin B complex by mouth is also at times of value. In the severe cases little can be done. I use the above routine plus periodic transfusions and hope the process will reverse. In most cases, however, it is irreversible. Splenectomy occasionally may be of help although it can hardly be recommended as a routine. In my experience adrenalin has been of no value.

Hemolytic Anemia

There is a wide group of hemolytic anemias which are congenital in origin. Congenital hemolytic icterus, Cooley's (Mediterranean) anemia, target cell anemia, and sickle cell anemia are all variants of this congenital process. Others are due to isohemolysis or agglutinins. Erythroblastosisfoetalis due to sensitization to the Rh. factor is one of these. Others are chemical and may be the result of sensitization to drugs as in the hemolytic anemia, occasionally following sulfonamide therapy. Still others are the result of hypersplenism as in Banti's disease and congenital hemolytic icterus.

Because these represent increased blood destruction rather than bone marrow disturbance the peripheral blood is rather characteristic. The erythrocytes are reduced and are normochromic and normocytic or microcytic. In the congenital types there are also certain characteristic changes in shape, such as spherocytic in congenital icterus, sickling in sickle cell, et cetera. The platelets and leukocytes are usually normal, but may be slightly abnormal either up or down. The reticulocytes are elevated, sometimes markedly, and normoblasts are nearly always present in the more severe cases.

The bone marrow, in attempting to compensate for the increased destruction, shows a marked hyperplasia of the erythroid elements, but no maturation disturbance and no abnormality of hemoglobin synthesis. Phagocytic elements are increased even in the bone marrow. Other elements are undisturbed.

The therapy of hemolytic anemia is somewhat tricky. Transfusions have their place in certain types, but are dangerous in others. In erythroblastosis and in those due to chemical sensitivity they are usually safe and may be quickly curative. In those in which hypersplenism is a factor, transfusions may increase the degree of hemolysis to a marked degree. In these the antilytic factor in plasma may be used to advantage. Human plasma, if given in large amounts, may produce a reversal of the destructive process and a satisfactory return to equilibrium may ensue. Finally, if hypersplenism is present and the case does not respond to the transfusions or plasma in a period of one or two weeks, splenectomy should be considered. Splenectomy if done early will cure many of these cases. If delayed too long its curative value decreases. Liver, iron, and other factors are usually not indicated in any of the hemolytic anemias because few if any of the products of red cell destruction are lost, but are returned for re-use by the bone marrow.

Myelophthisic Anemia

This final type of anemia will be discussed briefly since it involved a complex discussion of hematology. Certain aspects of it can be readily recognized, however, and these will be pointed out.

The cause of myelophthisic anemia is an inva-

sive growth of the bone marrow. This can be brought about by infection, such as tuberculosis or other chronic infections; by neoplasms, such as metastatic carcinoma; by bone disease, such as multiple myeloma; or by blood disorders, such as the leukemias.

The peripheral blood reflects the anemia as a normochromic, normocytic anemia, usually because the bone marrow reflects a mechanical rather than a physiological disturbance. The platelets are usually reduced or absent because the megakaryocyte seems to be a very fragile cell and is crowded out readily. The leukocyte picture will depend entirely on the type of process producing the disturbance. The reticulocytes are usually absent or low, but occasional normoblasts are common, reflecting the premature pushing out of nucleated erythrocytes.

The bone marrow is usually diagnostic, showing large numbers of the invading cell.

The therapy in this type is, of course, most discouraging. The therapy must be aimed at the disease causing the bone marrow invasion, and most of these are at present incurable. Liver and iron and all the other substances are without demonstrable physiological effect, but may be used for their "morale" effect. Transfusions are purely replacement therapy. Radiation therapy is of temporary benefit because most of the invasive cells are radiosensitive and thus will be temporarily inhibited. True therapy of this group of anemias must wait, however, on more adequate therapy of the diseases causing the bone marrow invasion.

Finally, a brief note in regard to mixed anemias: mixed anemias do occur, and we must always be on the alert for variations of these rather standard patterns so that proper variation in therapy may be instituted. I have seen pernicious anemias with an iron deficiency also due to blood loss, cases of hypersplenism with hypoplasia of the bone marrow, and myelophthisic anemias with a complicating hemolytic process. All of these possibilities must be watched for in any individual case, and proper therapeutic measures to combat complicating causes must be instituted.

Summary

(1) A brief summary of the physiology of erythropoiesis has been presented.

(2) Five general types of anemia based on this physiological knowledge have been presented.

(3) The therapy of the anemias based on our present knowledge of this physiology has been discussed.

A RARE ACCIDENT

F. E. HAGIE, M.D.

RICHMOND

D.E.T. was having trouble with the fuel pump of his car, and in attempting to correct the difficulty while the engine was running he got his left hand caught in the fan belt and pulley of the engine. He pulled back his hand with the left index finger caught between the fan belt and pulley, and the end of the finger was torn off. He had a sudden pain in the left forearm at the time.

He came to the hospital with a traumatic amputation of one and one-fourth phalanges of the left index finger. The end was trimmed off and the area closed.

After the patient returned home, he called me, saying that he had examined the end of the finger that had been torn off, and found the end to have a long piece of tissue hanging to it. He brought it in at the time of his first dressing, and it appeared as shown in the accompanying photo, being eleven inches in length.

The severing of the end of the finger was proximal to the distal joint of the finger, and the tendon of the Flexor profundus digitorum, attached to the base of the distal phalanx, was not cut with the amputation. With the end of the finger amputated and caught in the pulley, but with the tendon still attached, the pull caused the weakest point to give way, and that is where the tendon became a part of the muscle in the forearm. One can notice the small pieces of muscle tissue at points marked "A."

I have never seen this type of an accident before, and the factors necessarily had to take place as indicated above in order to get such a specimen. I feel that this case is of sufficient interest to warrant reporting.



Traumatic amputation of left index finger with tendon of the Flexor profundus digitorum attached to amputated phalanges.

ACUTE MYOCARDIAL INFARCTION AMONG YOUNG ADULTS

CAPTAIN RICHARD M. NAY, M.C.

INDIANAPOLIS

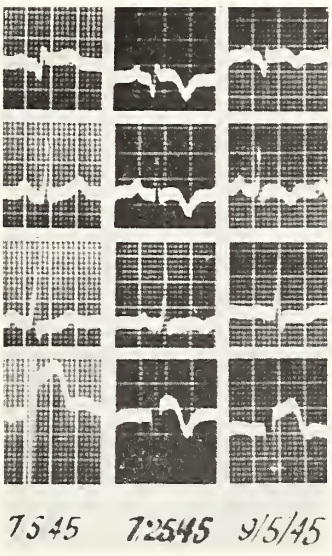
Because of the relative infrequency of myocardial infarction among young adults, it seems appropriate to report five cases occurring among soldiers. The patients were observed at the Foster General Hospital, a United States Army installation. The patients were all white males, and their ages were twenty-five, thirty, thirty, thirty-one, and thirty-eight years. In each instance the acute attack had occurred elsewhere, and the patients had been transferred to the Foster General Hospital during their convalescence. The diagnosis of myocardial infarction was made after a review of the clinical history, laboratory data, and examination of electrocardiograms taken at intervals during each patient's illness. All of the patients recovered. None of the patients were known to have had hypertension previous to myocardial infarction; in fact, normal blood pressure readings had been obtained at examination of each of the patients within three months preceding the acute attack. In none of the patients was there evidence of peripheral vascular disease.

Case 1. On July 4, 1945, this soldier was on duty at a gasoline pumping station in France. There was no history of antecedent pain in the chest or epigastrium. In the late afternoon, following his tour of duty, he engaged in wrestling with another soldier. After a bout of approximately ten minutes he sat down to rest before going to his quarters. Within a few minutes he was seized with a severe pain in the substernal area. He attempted to climb a flight of stairs to his room, but was unable to do so because of the severe pain and shortness of breath. He perspired profusely. He was taken to a hospital approximately thirty-five miles distant. Upon arrival at the hospital at 9:30 P.M. the pain was as severe as at its onset, and, in addition, had extended into both arms. Blood pressure was 116 mm. Hg. systolic, and 80 mm. Hg. diastolic. The pulse rate was eighty per minute. Morphine sulfate, grains one-fourth, was given immediately with transient relief. Because of recurrence of the pain, a similar amount was administered at 11:00 P.M. On July 5, 1945, white blood cells numbered 19,500 per cubic mm., and an electrocardiogram revealed a small Q_1 with elevation of ST_1 and $_4$. ST_3 was slightly depressed. This and subsequent electrocardiograms are reproduced in Figure I. The history is characteristic of myocardial infarction, and the electrocardiographic patterns are those of infarction of the anterior portion of the myocardium. On July 23, 1945, while he was still in bed, the patient noted pain in the left chest. He expectorated a small amount of bloody sputum. A pleural friction rub was present on physical examination. A roentgenogram of the chest revealed a small amount of fluid in the left pleural space. The nature of the pathology in the underlying lung tissue could not be determined. The patient's temperature was 101 degrees F. for the succeeding two days. Twenty thousand units of penicillin were administered every four hours during the febrile period. No definite diagnosis was made of this complication. The patient's subsequent course was without incident.

Case 2. This thirty-year-old medical officer was stationed at an air base in the United States. He had been in good health until May 3, 1945. On that day he participated in a game of softball, and while running bases he noted a constricting pain in his chest. During the morning of May 6, while mowing a lawn, he noticed a recurrence of the pain and shortness of breath. These symptoms forced him to stop his work. During the afternoon of the same day he played golf, and at the fourth hole a precordial pain occurred, extending into both shoulders and into the left arm. The officer persisted in playing golf, but had to rest after each of the succeeding three holes, at the end of which he was forced to quit because of the pain.

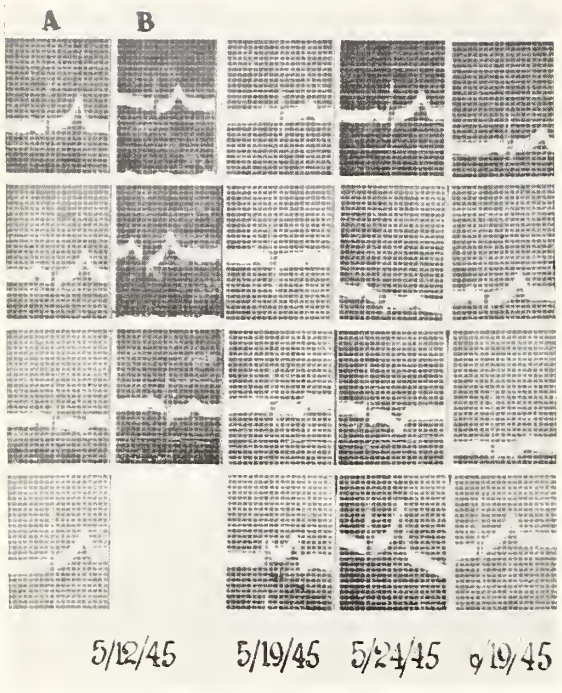
On May 8 he again played softball, and developed the most severe pain in the left chest that he had yet experienced. Sweating occurred, and he lay upon the ground and inhaled amyl nitrite. The pain was relieved in about five minutes. Because of his symptoms electrocardiograms were taken before and after exercise, on May 12, 1945. The

FIGURE 1



Case 1. The first electrocardiogram taken July 5, 1945, reveals a small Q_1 with elevation of ST_1 and $_4$ and depression of ST_3. The R wave in lead 4 is absent. In the subsequent tracings, T_1 and $_2$ are inverted, and T_1 is inverted in the electrocardiagram of July 25, 1945, and diphasic in that of September 5, 1945.

FIGURE II



Case 2. Electrocardiogram A, May 12, 1945, was taken prior to exercise, and is within normal limits. Electrocardiogram B, following exercise, reveals slight depression of ST segments in all leads, and reversal of T_3. These changes indicate myocardial ischemia. Myocardial infarction occurred May 18, 1945. The electrocardiogram of May 19, 1945, reveals T_3 to be diphasic, R_4 to be low, ST_4 to be slightly elevated, and T_4 to be diphasic. T_1 and $_2$ are of low voltage. A normal tracing was obtained on June 19, 1945.

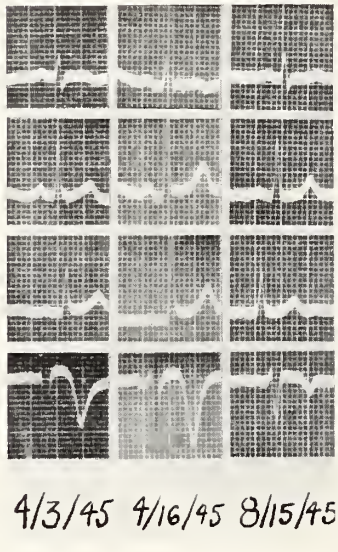
electrocardiogram taken before exercise was within normal limits. Following exercise the electrocardiogram revealed depression of ST segments in all leads, and T_3, which had been inverted previously, became upright. (See Figure II.) This is interpreted as indicating myocardial ischemia. Despite his previous symptoms and the electrocardiographic evidence of coronary insufficiency, the officer again played golf on May 13, 1945. Substernal pain occurred by the time he reached the third hole, and was so severe that he lay down on the ground before making a shot. During the period of May 13 to May 17 he noted that the pain occurred after walking two hundred to three hundred yards. In the evening of May 17 he ate a large dinner and had experienced no distress by the time he retired at 10:30 P.M. He was awakened at 12:45 A.M., on May 18, with severe substernal pain of a constricting nature. He perspired profusely. After approximately one-half hour he was given morphine sulfate, grains one-half, which relieved the pain. He was taken to a station hospital. During the succeeding two weeks he had mild substernal pains which were relieved by nitroglycerin. On May 18 white blood cells numbered 11,200 per cubic mm.; erythrocyte sedimentation rate was 21 mm. per hour. On May 25 white blood cell count was 8,150 per cubic mm.; sedimentation rate was 23 mm. per hour.

The history is considered to be typical of myocardial infarction. The electrocardiograms reproduced in Figure II reveal minimal abnormalities which are considered as confirmatory evidence of myocardial infarction.

Case 3. This thirty-one-year-old officer was en route by bus to his station in England on the morning of April 2, 1945, when he was seized with severe pain in the sternal region. The pain extended into the left arm. Upon reaching his station, approximately fifteen minutes later, he was given morphine sulfate, grains one-half. Forty-five minutes later an additional one-fourth grain was given because of persistence of pain. On April 4, 1945, erythrocyte sedimentation rate was 22 mm. per hour, and white blood cells numbered 7,200 per cubic mm. On April 6 the sedimentation rate was 37 mm. per hour. Electrocardiograms revealed a pattern of anterior myocardial infarction (Figure III). The patient's convalescence was without incident.

Case 4. This soldier was admitted to a hospital in Germany on July 28, 1945, because of epigastric distress of a vague nature. During the course of his examination an electrocardiogram was made. This revealed a pattern suggestive of anterior myocardial infarction. Inquiry into the patient's past history revealed that he had embarked on a boat which left the continental United States on April 24, 1944. During that night he had been seized with severe substernal or epigastric pain, accompanied by profuse sweating. He was so ill that he was carried on a litter to the ship's hospital, where he was treated with sedatives and rest in bed. The soldier stated that no definite diagnosis was made at the time of the illness, but that after five days he was released for duty. An electrocardiogram was not made at that time, and

FIGURE III



Case 3. Acute myocardial infarction April 2, 1945. In the electrocardiogram of April 3, 1945, T_1 and $_4$ are inverted. In that of April 16, 1945, T_2 and $_3$ are heightened and peaked in addition to the above-mentioned abnormalities. The electrocardiogram of August 15, 1945, reveals T_1 to be upright but of low voltage. T_3 remains inverted and R_4 is low.

he was not admitted to a hospital again until this time. It is thought that the attack which occurred on April 24, 1944, was an infarction of the myocardium. Electrocardiograms taken August 3, August 10, August 23, and October 19, 1945, revealed deep inversion of T_1 and $_4$. One of these tracings is reproduced in Figure IV. The patient was twenty-five years old in April, 1944. The complaints which precipitated his present admission to the hospital system were not considered to be associated with the cardiovascular system.

Case 5. This thirty-eight-year-old soldier was stationed at an air field in England. About mid-March, 1945, he noted that on walking to and from his work he developed mild substernal pain and shortness of breath. This gradually increased in intensity, and in addition the pain sometimes occurred when he attempted to lift heavy plane parts. In the morning of April 1, 1945, he was seized with severe substernal pain while walking from the mess hall to his barracks. The pain was so severe that he sat down on a curb, and an ambulance was called to take him to a dispensary. Although he was sweating profusely, and was in great pain, he was returned to his quarters after he had been given an opiate. The pain persisted throughout the day, and in the evening he was again taken to the dispensary, and this time was admitted to a hospital. He had a temperature of 100 degrees F., and his white blood cell count was 15,800 per cubic mm. The clinical diagnosis was acute myocardial infarction. An electrocardiogram was not taken until April 12, 1945, and at that time there was inversion of T_1 and $_4$ with absence of R wave in lead 4. This and subsequent electrocardiograms are reproduced in Figure V. The patient's convalescence was without incident.

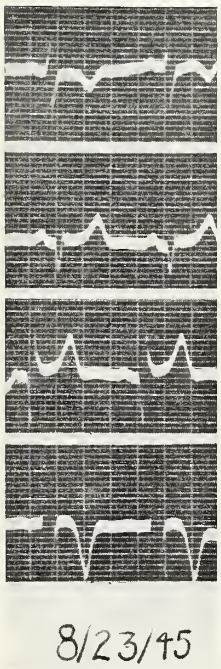
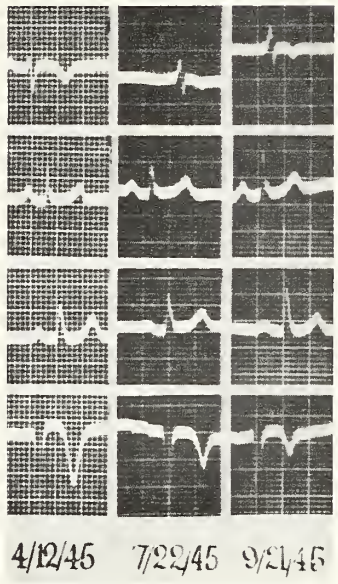


FIGURE IV

Case 4. Acute myocardial infarction occurred April 24, 1944. Electrocardiogram taken August 23, 1945, reveals deep inversion of T_1 and $_4$.

FIGURE V



Case 5. Myocardial infarction occurred April 1, 1945. The electrocardiograms present a pattern of anterior myocardial infarction. The significant abnormalities are the inversion of T_1 and $_4$ with absence of R wave in lead 4. In the electrocardiogram of April 12, 1945, T_3 is increased in height and slightly peaked.

DISCUSSION

In each of these cases a diagnosis of myocardial infarction seemed warranted. In cases 1, 2, 3, and 5 the histories and clinical symptoms presented by the patients were sufficient to lead to the diagnosis when the patients were first observed. The electrocardiograms substantiated the diagnosis in each case. In Case 4 the illness which is assumed to have been a myocardial infarction was not recognized as such at the time. In retrospect, it seems highly probable that infarction did occur on shipboard en route overseas. If this be true, it is likely that the period of inactivity enforced by a slow overseas crossing contributed to the excellent recovery of cardiac function which the patient experienced.

The incidence of myocardial infarction among individuals under forty years of age is unknown. In a group of 3,376 cases of myocardial infarction presented by Glendy, Levine, and White[1] the incidence was 1.54 per cent. The majority of reports of myocardial infarction occurring among young individuals makes no attempt at determining the incidence of occurrence. In 1944, Shullenberger and Smith[2] were able to collect 318 cases of myocardial infarction among patients less than forty-one years of age. To this group should be added the report of French and Dock, who studied 80 cases of fatal coronary arteriosclerosis among soldiers twenty to thirty-six years of age. Suffice it to say that the infrequency of occurrence of

[1] Glendy, R. E.; Levine, S. A.; and White, P. D.: Coronary Disease in Youth, *J.A.M.A.* **109**:1775-1781, (Nov. 27) 1937.

[2] Shullenberger, C. C., and Smith, H. L.: Posterior Basal Cardiac Infarction Affecting a Young Man, Followed a Year Later by Anterior Apical Infarction, *Am. Heart J*, **28**:429-434, (Oct.) 1944.

myocardial infarction in this age group should not deter the physician from entertaining the diagnosis when suggestive symptoms are presented.

It is important to note that two (Cases 2 and 5) of the five patients of the present group had symptoms which are characteristic of the premonitory symptoms of myocardial infarction. The appearance and frequent occurrence of angina pectoris in an individual previously normal is reason to suspect that myocardial infarction may soon occur. In individuals who have had angina of effort for a period of time, a sudden increase in the frequency or severity of attacks, or the appearance of angina at rest, is cause for alarm. Attention to these symptoms has been the subject of discussion of several authors.[3, 4, 5] The percentage of patients who suffer premonitory symptoms of myocardial infarction has been estimated to be from 18 to 50 per cent. Among a group of 100 patients with acute myocardial infarction studied by Barnes and the author, premonitory symptoms occurred in eighteen patients. These symptoms occurred long enough before the actual infarction and were definite enough to lead to the correct diagnosis in those two instances in which the patients presented themselves to a physician before infarction occurred.

It is in the group of patients having premonitory symptoms that treatment directed at avoiding infarction should be instituted. Until recently effective therapy has not been available. Theoretically, anticoagulants should be of aid in preventing intravascular thrombosis and myocardial infarction in those instances in which the latter is the result of thrombosis in a coronary artery. If the interruption in blood flow is due to intimal hemorrhage, infarction of the myocardium may yet be avoided, since in a goodly number of instances intravascular thrombosis is associated with intimal hemorrhage.[6, 7] Intimal hemorrhage alone as the cause of occlusion of a coronary artery apparently occurs infrequently, but in such cases it will be argued that prolongation of coagulation time may actually increase the chances of myocardial infarction. This argument cannot be dismissed without consideration, but it should be pointed out that this type of occlusion occurs in only a small percentage of cases, and that if infarction occurs the resulting zone of devitalized heart muscle may be smaller because of the prevention of thrombosis in the adjacent collateral vessels, both arteries and veins. The objections to anticoagulant drugs seem relatively unimportant when compared with the advantages which may accrue from their use. In addition, papaverine is probably of benefit in increasing coronary artery blood flow and should be employed.

[3] Boyer, N. H.: Premonitory Symptoms of Myocardial Infarction, New England J. Med. 227:628-633, (Oct. 22) 1942.

[4] Feil, H.: Preliminary Pain in Coronary Thrombosis. Am. J. Med. Sci., 193:42-48, (Jan.) 1937.

[5] Sampson, J. J., and Eliaser, M.: The Diagnosis of Impending Acute Coronary Artery Occlusion, *Am. Heart J.* 13:675-686, (June) 1937.

[6] Paterson, J. C.: Capillary Rupture with Intimal Hemorrhage as a Causative Factor in Coronary Thrombosis, *Arch. Path.* 25:474-487, (April) 1938.

[7] Wartman, W. B.: Occlusion of the Coronary Arteries by Hemorrhage into their Walls, *Am. Heart J.* 15:459-470, (April) 1938.

SUMMARY

Five cases of myocardial infarction occurring among soldiers, ages twenty-five to thirty-eight, are presented. Attention is directed to the relative infrequency of myocardial infarction among individuals of this age group, and to the occurrence of premonitory symptoms of infarction in two of the five patients whose cases are reviewed.

ADDENDUM

Since the above article was submitted, another patient with acute myocardial infarction has been observed. The patient is a colored male thirty-seven years of age. During the month of July, 1945, he noted shortness of breath and occasional precordial pain on exertion. In the morning of August 4, 1945, he was suddenly seized with excruciating pain over the substernal and precordial area. He was admitted to the hospital, where a diagnosis of myocardial infarction was made. Electrocardiograms revealed the typical pattern of infarction of the anterior portion of the myocardium. During the latter part of the patient's hospital period his blood pressure was consistently elevated, the systolic pressure varying from 170 to 190 millimeters of mercury, and the diastolic pressure varying from 100 to 120 millimeters of mercury. Examination of the ocular fundi revealed mild arteriolar sclerosis. In addition to the diagnosis of myocardial infarction, a diagnosis of essential hypertension, Group I (according to the method of Wagener and Keith[8]), was made. The patient recovered sufficiently to be discharged from the service.

[8] Wagener, H. P., and Keith, N. M.: Diffuse Arteriolar Disease with Hypertension and the Associated Retinal Lesions, *Medicine*, 18:317, 1939.

ANNUAL SESSION INDIANA STATE MEDICAL ASSOCIATION, OCTOBER 29, 30, 31, 1946.

Have you made your hotel reservation for the annual session of the Indiana State Medical Association?

THE HISTORICAL BACKGROUND OF MALARIA—A RECONSIDERATION

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EVANSVILLE

"Science without philosophy, facts without perspective and valuation, cannot save us from havoc and despair."—Will Durant.

In the flood of scientific development of the past sixty-five years there has been a notable tendency to seize upon new discoveries, discarding and forgetting much valuable knowledge as it came to appear outmoded by an ever-newer concept, or useless in comparison with a still more magic bullet. Too frequently there is no pause to re-evaluate and correlate almost forgotten facts and indirectly significant observations, as successive miracles seem to defy biological laws which yet remain immutable. Classification has been an effective password and a useful tool, but the Solomon to its David must be sought in correlation, in Proverbs rather than in Psalms.

Hippocrates surely smiles sagely and sympathetically as his modern colleagues rediscover the complexities and pernicious potentialities of the intermittent, remittent and bilious fevers. References to almost any practice of medicine as recent as Osler's 1896 edition should, and study of the current literature surely will, dispel the still prevalent impression which led Gillick (1938)[1] to remark, "It is astonishing in this day and age to see those whose minds are closed to the possibility of malarious infection manifesting itself in anything but a frank syndrome of chills, fever, and sweats."

We have not had the opportunity to study this so-called "tropical disease" in tropic climes, but it is related that a meeting in Indiana for the solicitation of foreign-mission funds was once practically broken up by one of the community elders arising to "Praise God, we got heathen right here at home."

After encountering plasmodia not infrequently in therapeutic infections† and occasionally in natural infections†† since 1933, we began in February, 1942, to be aware of a group of cases which at the time were interpreted as cases of malaria with parasites which were "hard to see." The failure to obtain confirmation of the smear diagnosis from several national authorities, the generally favorable response to specific treatment, and several fatalities in the absence of treatment left us sorely pressed between our own conscience, on the one hand, and the precipice of scientific folly on the other. We could not overlook the conclusion of Seagrave (1943)[2] that the ultimate criterion is the cure of the patient, but it appeared essential to increase our knowledge of malaria as at least a possibility in the differential diagnosis.

THE GENERAL CONCEPT OF THE ETIOLOGY AND TRANSMISSION OF HUMAN MALARIA

As detailed by Russell (1943),[3] it appears that the origin of the disease is shrouded in antiquity; but an etiological relationship between the intermittent fevers and low marshy places was clearly surmised while the animal nature of the disease and the probability of an insect vector was suggested as early as two thousand years ago. The mosquito as the insect vector was specifically suggested in 1717‡[4] and repeatedly thereafter. Though not new, the mosquito theory of transmission expounded by Manson, in 1894, was outstanding because he gained the attention of an industrious person too interested to be skeptical. The fact that Laveran, in 1880, had recognized the living parasitic nature of the causative agent, although the parasites had been seen but not recognized by at least three workers previously, provided the essential tool for further study. Of this Ross made brilliant use.

It came to be generally accepted that the multiplication of the malarial parasite in the human body, and very strictly within the erythrocytes, was entirely asexual. It was recognized also that certain forms are produced which are distinct from the ordinary asexual forms; their nature seems to have been unsuspected until MacCallum in 1897-98 recognized that they represented male and female forms. He together with Opie saw male parasites of human malaria exflagellate, and

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[1] Gillick, D. W.: Masked Intermittent Malaria, *Oklahoma State M.J.*, **31**:404, 1938.

† According to Dr. W. L. Breutsch this strain of P. vivax "has been used continuously at the Indiana Central State Hospital since 1929, when it was received from the New York Psychiatric Institute, where it had already passed through more than three hundred paretics, without appreciable change in virulence or morphology. The quotidian type of paroxysm is seen in 75 to 80 per cent of the cases, while some cases show a shift from one to the other of the tertian or quotidian types. I have never seen any pernicious syndromes, such as blackwater fever, with the use of this strain."

†† Both P. vivax and P. falciparum.

‡ Susruta, Fifth Century A.D., described malarial fever, attributing it to mosquitoes (Walsh, 1934).[4]

[2] Seagrave, Gordon S.: *Burma Surgeon*, W. W. Norton & Co., Inc., New York, p. 59, 1943.

[3] Russell, Paul F.: Malaria and Its Influence on World Health, The Herman Biggs Memorial Lecture, *Bull. N. Y. Acad. Med.*, **19**:599, 1943.

[4] Walsh, James J.: History of Ancient Medicine, *Tice's Practice of Medicine*, vol. **1**, p. 7, W. F. Prior Co., Hagerstown, Md., 1934.

then saw one of the flagella penetrate and thus fertilize a female parasite. Ross, about the same time (1898), observed a pigmented malarial parasite growing within the stomach wall of an Anopheles mosquito that had fed exclusively on a patient whose blood contained crescents. Thus, eighteen years after Laveran's discovery of the parasite, its libidinous tendencies were first exposed and a love-nest revealed in the stomach-wall of Madame Anopheles. The particular enticements by which she so effectively cornered this assignation trade have never been disclosed. The following year Ross completed his demonstration of a bird-to-mosquito-to-bird cycle in avian malaria. In the same year (1898) Bignami, Bastianelli and Grassi were the first to prove a man-to-mosquito-to-man cycle in human malaria, and to show that it is transmitted probably by only one genus of mosquito—Anopheles. Not to be overlooked was the new method of staining blood smears, developed by Romanowski in 1891. Russell characterizes this as "of the greatest usefulness in all subsequent studies of malaria parasites," although every one of the above discoveries seems to have resulted from the use of wet preparations (and in the case of Laveran, from the use of a 4 mm. lens).

While there has been much work of a generally confirmatory nature, it is apparently upon these basic observations, walled by conclusions and painted with Romanowski stains, that the current concept of malaria was built and stands. In summary, the actually observed *facts* are:

1. A protozoan parasite.
2. An asexual cycle seen in the erythrocytes of man.
3. Sexually differentiated forms observed in the erythrocytes of man.
4. A sexual cycle, (syngamy characterized by copulation of the anisogamy type).
5. Copulation has been observed in human blood outside the human body and in the stomach contents of the female Anopheles mosquito.
6. Completion of the sexual cycle has been demonstrated in the mosquito named.
7. Man-to-mosquito-to-man transmission of the parasitic infection has been established.

From these facts comes the *concept* that:

1. The parasite is strictly one of the red blood cells in the intermediate human host, where multiplication is strictly asexual, the sexual forms developed becoming degenerative and extinct unless taken up by the definitive invertebrate host; and
2. The only source of human infection in nature is the bite of a female Anopheles mosquito, this definitive host having previously fed upon an infected human host and sufficient time having elapsed for a sexual cycle of parasitic development to occur.

This gem of logic has stood up sufficiently well that evidence in question thereof has been repeatedly disregarded and generally forgotten. Both Ross and Grassi observed occasional peculiar brown or black cysts on the stomach of mosquitoes in place of the normal ones. Wenyon (1926)[5] relates that the color was due to certain dark bodies within the cyst, either sausage-shaped, rounded, oval or irregularly lobed, each composed of minute brown granules embedded in a clear substance which was not enclosed by any membranes. Various suggestions have been made as to the nature of these black spores. "That they are spores of a microsporidian cannot be entertained, as they do not bear any resemblance to these." It has been suggested that they are probably the result of death and degeneration of the oocyst contents at various stages of development, and that chitinous material may be deposited in them. Strong (1942)[6] states that they have been found in mosquitoes not infected with malaria, but quotes Brumpt as saying in 1938 that in the study of a lot of mosquitoes he had found them only in those that had fed on infected fowls, and that he thought they were evidence that infection of the mosquito had occurred. Thus, their nature remains doubtful although they are apparently related to malarial infection in the mosquito.

Celli (Craig)[7] postulated a sexual cycle in man. Lawson (1911)[8] claimed that the sexual cycle of P. falciparum which normally takes place only in the mosquito may occasionally occur in the blood of man. The first successful cultivation of the malarial parasite was announced by Bass in 1911, the actual technique employed being published by Bass and Johns in 1912.[9] The original technic was quite elaborate. The later statement of Bass (1932),[10] "that further experience has shown that the plasmodia grow as well at 37°C as at higher temperatures and it is not necessary to remove the leukocytes by centrifugalization in order to grow more than one generation," seems to indicate almost practical simplicity. The 1932 article is noteworthy for the wealth of information on malaria in general, but particularly so in that it contains one of the few references thus far encountered as to the changes in morphology and staining reaction as the parasite dies. Even here the staining property is mentioned only as being poor or lost. The human cycle as the center

[5] Wenyon, C. M.: *Protozoology*, Wm. Wood & Co., New York, 1926.

[6] Strong, R. P.: *Stitt's Diagnosis Prevention and Treatment of Tropical Diseases*, Sixth Edition. The Blakiston Co., Philadelphia, 1943.

[7] Craig, C. F.: Malaria, *Tice's Practice of Medicine*, W. F. Prior Co., Hagerstown, Maryland, 1934.

[8] Lawson, M. R.: The Aestivo-autumnal Parasite, Its Sexual Cycle in the Circulating Blood of Man, *J. Exper. Med.*, **13**:263, 1911.

[9] Bass, C. C., and Johns, Foster M.: The Cultivation of Malaria Plasmodia in Vitro, *J. Exper. Med.*, **14**:567, 1912.

[10] Bass, C. C.: Malaria, *Tice's Practice of Medicine*, W. F. Prior Co., Inc., Hagerstown, Md., 1932.

of interest is indicated very definitely when Bass casually mentions that he has seen zygotes as much as four days old still alive, but that he has never made any great effort to culture this sexual cycle of the parasite, nor is he familiar with any of the work performed by others with this object in view. "There is no doubt that the sexual cycle of malaria parasites can be cultivated whenever suitable technic is employed."

Cultivation of the sexual cycle was claimed by Joukoff (1913)[11] and by Perekropoff (1914),[12] but those reports, like that of Lawson, have not been generally convincing.

Craig and Faust (1943)[13] take recognition of the "exo-erythrocytic" cycle of malarial parasites, which has apparently been established in avian infections with P. elongatum, P. relictum and P. gallinaceum. The literature on this subject was more extensively reviewed by Porter and Huff (1940).[14] This cycle has admittedly rattled the skeleton of protozoan classification. Craig and Faust (1943)[13] cite reports of similar forms in man: by Raffaele in 1937, by Casini in 1939, by Brug in 1940, and by Kikuth and Mudrow in 1941. They conclude that, "from a practical viewpoint this discovery has far-reaching implications. It strongly suggests that there may be an exo-erythrocytic residuum of infection . . . which may be the source for both asexual parasites and gametocytes in relapse."

Kikuth and Mudrow (1941)[15] mention additional observations of the "E-forms" in human malaria by Bianchi and by Taristano and Lucrezi. They list the forms observed as: non-pigmented mono- and bi-nuclear forms, three non-pigmented forms, a pear-shaped elongated mononuclear parasite, two large freely-suspended schizonts with eight to ten nuclei, two mononuclear intracellular and one multinuclear forms, a binuclear nonpigmented form still loosely connected with the host cell, bi-, tri-, and tetra-nuclear forms, a rotund tetranuclear form, and two large schizonts with about forty nuclei. Assuming that "there can be no doubt about the existence of a reticulo-endothelial phase closely related to the sporozoites in human malarial parasites," they reason by analogy with similar forms in avian malaria that here we have a very resistant form of Plasmodium which makes positive prophylaxis thus far impossible and which is responsible for the late recurrence of the disease after an apparently successful treatment. Dr. C. G. Huff (personal interview 1944) is not convinced that exo-erythrocytic forms have been demonstrated in man.

Shortt and Menon (1940)[16] were able to infect monkeys and birds by feeding them blood containing their respective malaria plasmodia. Moreover, they recognize the probable and apparent importance of the size of the infectious dose.*

Derived from free-living ancestors by way of the coccidia, the so-called Genus Plasmodium has reached an advantageous level of parasitic development. From the early colonies in the alimentary tract of various arthropods those in the blood-sucking mosquitoes have become prominent. The fate of other colonies remains unsung. The domestication of the human host was not entirely without difficulty, but that it has been effectively accomplished is indicated by the following observations. Strong (1942)[6] states that from the standpoint of prevalence, malaria appears to be the most important of all (human) diseases in the world today. Figures cited in this regard force the conclusion that wherever the incidence of malarial infection has been studied, 100 per cent has been approximated in proportion to the persistence of the observer. Coggeshall (1943)[17] recalls that it is not unusual to read reports of malarial surveys in countries where the rate of infection is 100 per cent of the population, and that the disease in epidemic form occurs not only in the tropics but also within the Arctic Circle. Colonel L. D. Moore (1944) tells us that in Liberia children are not named until two years of age, and attributes this to the futility of wasting names in the face of the high rate of infant mortality from malaria. The records of host-mileage are generally familiar in the late relapses and instances of late transmission by blood transfusion. The possibility of surviving the host by the luxury-line of congenital transference is indicated by some eleven cases of human congenital infection cited by Strong (1942)[6] and by the additional reports of Cohen (1943).[18] These instances are generally regarded as exceptions dependent upon some injury to the placental barrier of the host.

MALARIA IN COLONIAL AND PIONEER AMERICA

Childs (1940)[19] has reviewed the relationship of malaria and colonization along our southeastern seaboard from the standpoint of the social his-

[11] Joukoff, N. M.: Culture du parasite de la malaria, *Comptes rendus Soc. de biol.*, **74**:136, 1913.

[12] Perekropoff, G.: Ueber Kulturen der Plasmodien des tropischen Fiebers, *Archives Protist.*, **35**:139, 1914.

[13] Craig, C. F., and Faust, E. C.: *Clinical Parasitology*, Third Edition, Lea and Febiger, Philadelphia, Pa., 1943.

[14] Porter, R. J., and Huff, C. G.: Review of Literature on Exo-Erythrocytic Schizogony, *Am. J. Trop. Dis.* **20**:869, 1940.

[15] Kikuth, W., and Mudrow, L.: Malariaprobleme im Lichte neuer parasitologischer Erkenntnisse, *Deutsche Med. Woch.*, **67**:85, 1941.

* A basic concept in infectious disease and immunology, given little attention in human malariology where emphasis has been given to the observation that the bite of one mosquito is sufficient to cause malaria, and to the idea that one parasite inoculated is sufficient to produce symptoms.

[16] Shortt, H. E., and Menon, K. P.: Experimental Reproduction of Monkey and Avian Malaria by an Unusual Route of Infection, *J. Malaria Institute of India*, **3**(1):159, 1940.

[17] Coggeshall, L. T.: Malaria as a World Menace, *J.A.M.A.*, **122**:8, 1943.

[18] Cohen, R. R.: Obstet. & Ginec. Lat.-Amer., 1943 (Abstr.: *Lancet*, Jan. 29, 1944).

[19] Childs, St. Julien Ravenal: *Malaria and Colonization in the Carolina Low Country*, Johns Hopkins Press, Baltimore, Md., 1940.

torian, and concludes that the similarity of the Carolina colony and malaria-free Barbados implies that the disease lacked power to determine social patterns. "Man being mortal, disease is mighty over the individual; society being immortal, it is permissible to believe that parasites and viruses have played an unimportant role in social history." In brief review the following points of evidence leading to this conclusion have interested us. Englishmen settled near the present site of Charleston in April, 1670, beginning the earliest unbroken occupation of this area by people of European stock. Fever and ague were reported the following September after severe food shortages through the summer. Debility and listlessness were prevalent in March. For meat, first dependence was beef, salted or dried, and it seems to have been about three years before there was a significant amount of home-grown pork. The English, like the Spanish, found the winters more sickly than the summers. A mild form of malaria may have become endemic by the fall of 1680; in 1682 it was reported that "most have a seasoning but few die." The year 1684 saw more fatal malaria than before experienced and appears to have been the turning point with the following years progressively less bad. After the disease became endemic the injuries inflicted appear to have been relatively superficial and transient. "Naturalization of malaria in 1678-1696 made certain its existence thereafter." In the eighteenth century malaria again became virulent, "presumably the result of the opening of African trade."

Faust (1943)[20] brings the history of Charleston up to date by indicating it as included in one of three areas of high endemicity persisting in the United States, which areas, "both in size and intensity of infection, compare very favorably with the much denser malarious areas" of the world. The other areas in this country include the so-called "delta area of the Mississippi, from Cairo, Illinois, down to Natchez, Mississippi, and a small area at the mouth of the Rio Grande. He further describes an area of endemicity extending from central Texas through eastern Oklahoma and Missouri to the southern part of the Great Lakes area, and even into central New York State.

Stage (1944)[21] cites the report of Sir James Douglas, "Oct. 11, 1830: A dreadfully fatal intermittent fever broke out in the lower parts of this (the Columbia) river about eleven weeks ago, which has depopulated the country. Villages which afforded from one to two hundred effective warriors are totally gone; not a soul remains. I am one of the few persons among the Hudson Bay Company's people who have stood it, and sometimes I think even I have got a 'shake' and can hardly consider myself out of danger as the weather is very hot."

Strong (1942)[6] states that a mild endemic area persists in the valley of the Columbia River.

It is stated (see Upjohn's *Scope*, June, 1944) that in Michigan one hundred years ago, malaria incapacitated a large number of the population every summer and that the conditions for transmitting malaria are still present in Michigan, as illustrated by a small epidemic in 1928.

Russell (1943)[3] states that in 1901 in one section of Staten Island, 20 per cent of the inhabitants had malaria.

Returning to our provincial "heathen," Jackson (1939)[22] recalls that Indiana in the early days was notorious as an endemic malarial region, the Wabash Valley having been called one of the most famous malarial districts in the world. Vincennes was settled by the French Canadians about 1702, but the first general immigration into the state came by way of the Ohio River from Virginia, Kentucky, and the Carolinas. The southern part of the state was thus settled in the late eighteenth and early nineteenth centuries. The National Road which carried a second wave of immigration (Cumberland, Maryland, to Indianapolis) was not opened until 1834. The story (Marshall, 1914)[23] of suffering from ague forms a pathetic part of the history of pioneer life. To newcomers it was a veritable terror; in the fall everybody looked pale and sallow, the disease being no respector of persons. From the first of August to the first of October each year no serious labor was undertaken; sickness reigned supreme. At any gathering half wore yellow faces and moved about with heavy lassitude. The symptoms began with a chill of rather indefinite duration, followed by a burning fever which lasted for hours, sometimes every day, but more often on alternate days (Vogel, 1914).[24] The years 1820, 1821, and 1822 were attended by more general and fatal sickness than has ever been experienced before or since in the west. (This statement from Colonel Merrill, one-time state treasurer, apparently dates about 1825). Palastine on the east fork of White River, then the seat of Lawrence County, was nearly depopulated. Vevay, Jeffersonville, Vincennes, and many other towns lost one-eighth of their inhabitants the first year and probably nearly one-fourth in the three years. During this time in most neighborhoods there were but few persons

[20] Faust, E. C.: Malaria, *Northwest Med.*, **42**:278, 1943.

[21] Stage, Harry L.: Saboteur Mosquitoes, *Nat'l. Geog. Mag.*, **85**:165, (Feb.) 1944.

[22] Jackson, J. W.: Malaria in Indiana, *J. Ind. St. Med. Assoc.*, **32**:305, 1939.

[23] Marshall, George A.: Prevalence and Manifestations of Malaria, *J. Ind. St. Med. Assoc.*, **7**:402, 1914. (See also: Knabe, Helene: Report of the Investigation of an Epidemic at Young America, Indiana, *Twenty-sixth Annual Report of the Indiana State Board of Health*, Indiana State Board of Health, Indianapolis, 1907, p. 81.)

[24] Vogel, William S.: Home Life in Early Indiana, *Magazine of History*, **10**:1, (June) 1914.

who escaped without one or more severe attacks of fever. The prevailing diseases were biliousness and remittent fevers. At the new capital, Indianapolis, the year 1821 was the worst, there being only three persons in the settlement who were not prostrated, (Dunn, 1919).[25] Dr. Pennington describes his treatment of fever and wild delirium (remittent fever) by venesection and bleeding to the point where the pulse was soft and less resistant or until syncopy intervened (Ibid). Hindostan was a lusty frontier town in 1820. Its mills and business houses were advanced beyond anything in Southern Indiana outside of Vincennes and New Albany, but about 1826-27 the hand of fate closed down on the thriving city. It is said that there were more dead than living in the town at times. There was no resident physician and no positive identification of the malady which struck from the face of the earth the town of Hindostan (McCarty, 1914).[26] It seems entirely probable that this was the result of malaria.

The Rappites of the Harmonie settlement (1814-24) left behind 239 dead, although it is not certain just what may have been the cause. The population of the settlement appears not to have exceeded one thousand at any time. The death rate is said (Lockwood, 1905)[27] to have been very high in the first five, and especially the first two years. This has been attributed to malaria by various writers. A 20 per cent mortality during a ten-year period in a band of pioneers is somewhat high. It is not attributable to enemy attack, and the absence of any recorded cause is perhaps in favor of malaria. No mention is made of malaria in John S. Duss's book nor in William Owen's diary which describe both the Harmonie and Owen experiments; there are brief references indicating that the town and Rappite land around was well drained. However, one of the older residents, now eighty-seven years old, states that in his early days malaria was quite common through all the country around, from about July until frost came. Children from the bottom lands frequently had "ager cakes."

Dr. Sutton (1885)[28] gave the following account. "In 1838 the Laughery Valley, a few miles below Aurora, was visited by a malignant form of malarial fever different from anything that I have seen since, with the exception of a few sporadic cases. Intermittents were prevalent that autumn over the whole country, but along this valley we had a modification of remittent with what we regarded at that time as congestive fever. The patient would be seized with a slight chill, followed almost immediately by profound coma or congestion of some organ, and very frequently died before a physician could be procured. In other cases the chill was followed by fever, delirium, and great irritability of the stomach. There was generally in such cases a remission, but no well-marked intermission. The conjunctiva in a few days assumed a yellowish or jaundiced appearance. These cases we regarded at that time as bilious remittent fever, but we probably had every form and type of malarial fever in this locality. I think I can safely say that every family was more or less unwell, and in many families all were bedfast. As there were several persons sick in each house, the physician in his daily round could attend a large number of patients. In 1862 we had an epidemic of purpura, generally known by the name of spotted fever, in which there were a number of deaths; some of the patients died within twenty-four hours from the first symptoms of the attack. The skin became covered with purple spots of irregular size. In the cases that I saw there was but little fever; the pulse was small and feeble and the patient remarkably prostrated. Sometimes there was hemorrhage from the nose, and in one case I saw there was hemorrhage from the bowels. None of the cases that occurred in the neighborhood of Aurora were connected with such marked symptoms of cerebrospinal meningitis, although I am informed that this complication occurred in other places." Dr. Sutton does not identify this latter disease as malaria, leaving the etiology in doubt; however, it is the best description which we have been able to find anywhere of some of the cases which have recently attracted our attention.

The present writer's father recalls that his grandfather, who settled in Henry County, Indiana, in 1832, used to say that he dreaded the late summer season when stagnant ponds were covered by a green growth. This was ague time and nobody seemed immune. "Grandfather himself had many attacks which were taken as a matter of course. My father said he had had many attacks, although none were within my memory (that is, since 1886-87); he did have more or less regular attacks of sick headache, about once a week. The prominence of a seven-day cycle of relapse gave rise to the common term 'seven-day ague'."*[29]

The removal of the Mayo family from Indiana to Minnesota in 1854 is attributed to exasperation

[25] Dunn, Jacob Piatt: *Indiana and Indianians,* vol. II, p. 801, American Historical Society, Chicago and New York, 1919.

[26] McCarty, Carlos T.: Hindostan, A. Pioneer Town of Morgan County, Indiana. *Magazine of History,* **10**:864, (June) 1914.

[27] Lockwood, George B.: *The New Harmony Movement,* Appleton, New York, 1905.

[28] Sutton, George: A Review of the Epidemics That Have Occurred in Southeastern Indiana During the Past Fifty Years, and Observations on Change of Type in Our Endemic Malarial Diseases, *Tr. Ind. St. Med. Assoc.,* **35**:104, 1885.

* We have not encountered this term in the literature, although it seems to be familiar to several of the older local physicians. Fonde (1939)[29] mentions a seven- to ten-day periodicity in chronic malaria.

[29] Fonde, George H., and Fonde, Edgar, C.: Chronic Malaria, *Arch. Int. Med.,* **64**:1156, 1939.

under the debilitating effects of malarial chills and fever (by Clapesattle, 1943).[30]

The Annual Reports of the Indiana State Board of Health show 355 deaths from malaria in 1883; 296 in 1884; 428 in 1885; 222 in 1886; 257 in 1887; 116 in 1889; 207 in 1890, and 137 in 1892. Exact figures do not appear for some decades thereafter although the graphic presentation of causes of death includes malaria in at least some of these years. The Third Annual Report, 1884, is accompanied by the statement, "We are fully persuaded that the prevalance of malarial diseases which marked the past decade will never again recur in Indiana. The removal of the dense forests and the growth of underbrush which originally covered so large an area of our state, together with the drainage of the immense ponds, swamps, morasses, prairies and marshes has permanently relieved the state of that degree of malarial poisoning which formerly prevailed, and, with the rapid extension of underground drainage and the proposed removal of superfluous water along the Kankakee and other parts of the northern portion of our state, we confidently expect a steady diminution in malarial diseases." Another paper included in the same report (Vinnedge, 1884)[31] stated, ". . . the chief drawback in the prosperity of the Wabash Valley, if not the entire state, has been malarial fever, complicated and uncomplicated with either neuralgia, diarrhea or dysentery, and this source of injury, though less, has not disappeared, and will not be reduced to a minimum until the soil is drained and further cultivated." While these statements must have seemed of utmost importance then, they gain double significance as we find that in 1900 the President of the Marion County Medical Society[32] in welcoming the 10th Annual Conference of Indiana Health Officers proclaimed, "Now if for scientific purposes we desire to study the plasmodia malariæ we must seek it instead of its seeking us. Let us hope that to perpetuate the memory of the 'old man of the marshes' it will soon be necessary to dig a ditch to represent his tomb and place upon it as a fitting monument a large bottle of quinine." The drainage and clearing so effectively propagandized two decades before, more or less accomplished, it necessarily followed in syllogistic logic that malaria was a menace passed and gone. The figures on positive blood smears looked small indeed compared to those in the earlier years when mortality was reported.

The first examination for malarial parasites in Indiana is credited[33] to Dr. Theodore Potter, who in 1893 found crescent forms in the blood of a Dr. McShane.

No smear examinations are reported by the Indiana State Board of Health until 1906. The reports for several years thereafter are compiled in Table I.

For the seven years, 1909-1916 exclusive of 1913, the average number of positive smears was thirteen per year. In this same period the ninety-six positive smears which were classified included: P. vivax 76.5 per cent, P. falciparum 15.7 per cent, unidentified 7.8 per cent.

Interpretation of these figures may be made according to either of two schools of thought. One does not admit that P. falciparum should occur here, and hence would totally discount them, especially as concerns P. falciparum incidence. The second would consider them subject to evaluation. If, as seems probable, the diagnosis of P. falciparum was based upon the finding of crescents, then the reported incidence should not be discounted but tripled (upon the basis of Craig's observation that only about one case in three of P. falciparum infection develops gametocytes.) This would give a figure nearer 47 per cent, which is more compatible with the strong

[30] Clapesattle, H. B.: *The Doctors Mayo*, Garden City Publishing Co., Inc., Garden City, N. Y., 1943.

[31] Vinnedge, W. W.: Drainage for Health, *Third Annual Report of the Indiana State Board of Health*, Indiana State Board of Health, Indianapolis, p. 10, 1884.

[32] Morgan, W. V.: Address of Welcome, 10th Annual Conference of Indiana Health Officers, *Nineteenth Annual Report of the Indiana State Board of Health*, Indiana State Board of Health, Indianapolis, p. 333, 1900.

[33] Schweitzer, A. E.: Notes on History and Present Status of Malaria in Indiana, *Twenty-eighth Annual Report of the Indiana State Board of Health*, Indiana State Board of Health, Indianapolis, p. 248, 1909.

TABLE I

MALARIA SMEARS REPORTED FROM INDIANA STATE BOARD OF HEALTH LABORATORY

Year	Total Examined	Total Positive	CLASSIFICATION		
			P. vivax	P. falciparum	Unidentified
1906	13	2	?	?	2
1907	40	5	?	?	?
1908	121	5	?	?	5
1909	194	17	10	2	5
1910	189	11	7	3	1
1911	203	24	18	4	2
1912	?	6	5	1	0
1913	?	?	?	?	?
1914	146	10	9	1	0
1915	146	6	5	1	0
1916	169	22	19	3	0

TABLE II

INCIDENCE OF MALARIA BY MONTHS
ADAPTED FROM
ANNUAL REPORTS INDIANA STATE BOARD OF HEALTH

Month	Deaths Reported In 1887	Positive Blood Smears 1909-1911	
January	Least	None	
February	Least	None	
March	Intermediate	Slight	
April	Intermediate	Slight	
May	Intermediate	5	Highest
June	Intermediate	4	
July	Intermediate	10	
August	High	6	
September	High	9	
October	High	8	
November	Least	Slight	
December	Intermediate	Slight	

historical emphasis on autumnal illness. (Since the preceding paragraph was written, inquiry to Ada E. Schweitzer, M.D., who reviewed the slides in question, has been answered as follows: "As I recall, the specimens were stained and examined for crescents.")

It has usually been assumed that the discrepancy in malarial incidence before and after the "smear positive" criterion was introduced is explained by a mistaken diagnosis of malaria in the earlier days. In this connection there is close correlation between the monthly incidence of malarial deaths reported in 1887 and the reports of positive blood smears in 1909 to 1911. (See Table II.)

The mystery of malarial etiology had been dispelled and a diagnosis of malaria without the demonstration of Plasmodium was distinctly unwarranted in the better circles.

The fallacy of the syllogism thus compounded was raised to the *n*th power of delusion by several other illusionary factors, among which must be considered:

1. Relative stabilization of the population with a considerable proportion of second and third generation natives.
2. A degree of immunity and/or tolerance resulting from acquired and congenital infection.
3. Diminished exposure to mosquitoes.
4. Diminution of infectious dosage as a result of the above.
5. Possible diminution of virulence or reaction under circumstances altered as above.
6. Adaptation of the parasite to the altered environment.
7. An increasing proportion of more obscure clinical pictures.*[34]
8. The clinical assumption that parasites would be recognized by anyone who undertook to look for them.
9. The pathological assumption that in many cases, especially in chronic infections by P. falciparum, parasites could not be found in the peripheral blood.
10. Perhaps most significant of all, the sparsity in the scientific literature of any description of plasmodia other than those found in the classic plates, usually drawn by artists rather than the author of the text. Here science seems to have accepted a blind end and to have enjoyed a dull curiosity as to what happened to the plasmodia once they did not appear in classic form.

That malaria has *not* been eliminated from Indiana is apparent from recurrent references to it. An increase was noted during 1929-30, and thereupon the disease was made reportable in Indiana (Harvey, 1931).[35] Jackson (1939)[22] states that "Cases and deaths continue to be reported from time to time and beyond doubt there are more cases and deaths which are unreported. It is well to remember that anopheline mosquitoes are found in almost every part of Indiana. During the years 1933-38, one hundred thirty-one cases of malaria* were reported from twenty counties, (there being ninety-two counties in Indiana). Aestivo-autumnal parasites caused four cases with two deaths in Lawrence County in 1936, and four cases with three deaths in Gibson County in 1937; each of these outbreaks was at first supposed to be arsenic poisoning. Often one detects an undercurrent of reluctance among doctors to report a condition generally regarded as long since completely eradicated." A minor epidemic occurred in Vigo County in 1938; sixty-five cases were reported and a total of at least 1500 was estimated.[22]

Malarial therapy for paresis has been in extensive use in Indiana. The paretics so inoculated have been considered repeatedly to be a source of danger as carriers, and there is evidence (see Jackson, 1939[22]) that suggests a spread to the civilian population surrounding one of our state hospitals for the insane.

Rice (1943)[36] warned that there was increased danger of malaria because "there is a great deal of dead water standing in various low places over a large portion of the state" as a result of the worst flood of the Wabash Valley since 1913, and "because there has been for some years a small nidus of this disease in Indiana." It is not indicated which of the twenty to fifty-one

* Taliaferro (1929)[34] cites various studies in avian malaria where following the use of small infectious dosage (possibly with a lowered virulence) the birds had only a light, or no apparent attack, but were subsequently immune to superinfection, while their blood would set up the infection when injected into a normal bird.

* Later figures exhibited by C. G. Culbertson and W. H. Headlee (A.M.A. Convention, 1944) indicates 291 cases from 51 counties in the 1932-43 period.

[34] Taliaferro, William H.: *The Immunology of Parasitic Infections,* The Century Co., New York, 1929.

[35] Harvey, V. K.: Malaria In Indiana, *Month. Bull. Ind. St. Bd. Health.* **34**:49, 1931.

[36] Rice, T. B.: The May Flood of 1943, *Bull. Ind. State Bd. of Health,* (June) 1943.

counties previously mentioned constituted this small nidus.

Turning attention to Vanderburgh County and the adjacent area in particular, it is of peculiar interest to note that the southwestern part of Indiana called the "pocket" was a dense wilderness, and it was not until about 1815 that there was an opportunity for a physician to practice his profession, owing to the county being so sparsely settled. Dr. Hornby, an Englishman, was the first to settle (1818) within the present limits of Vanderburgh County. "The first widespread disease with which he had to contend excepting the ever-present effects of malarial poisoning was milk sickness," (Bray, 1889).[37] In 1836 remitting and intermitting fevers prevailed in epidemic form (Ibid).

Dr. W. R. Davidson states that malaria was endemic from 1870-1880 and up until 1900. Dr. Herman Baker recalls that about thirty years ago the surgeon most active in St. Mary's Hospital had a standing order to begin quinine grs. iii, t.i.d., on the second postoperative day.

Numerous personal interviews with physicians veteran in local practice have been most informing; these are too numerous to cite individually. The consensus, however, is that they have all seen much malaria, especially in the earlier days of practice. Almost every one of them was at first somewhat reluctant to say much about it (least of all to a pathologist), but once the initial reserve was broken there was a literal flow of citations of experience with chills and fever; this in most instances included personal experience. They seemed to have found that smear examination was frequently non-confirmatory in recent years. Some were apparently convinced that they must be wrong; others were in the habit of giving antimalarial therapy to any patient who was not responding as might be expected to other treatment. The results of the latter group were surprisingly good, and very appealing to a pragmatist (See Johnson, 1939[38]).

Almost any native of the locality will recount personal experience with chills and fever in childhood. Many remember the routine line-up of all children of the family for their regular dose from the quinine bottle. It is still not uncommon among the farm families to summon a physician only after therapeutic trial of the same bottle has failed.

Dr. C. C. Sutter contributes the following parody as one commonly heard in the community since his childhood:

"The fever and the ague are something awful
And chills are situated there to stay.
The people shake from town to town,
On the banks of the Wabash far away."

[37] Bray, M. J.: Medical Profession (Chapter 7) *History of Vanderburgh County, Indiana.* Brant & Fuller, Madison, Wis., 1889.

[38] Johnson, Gardner C.: Chronic Low Grade Malaria, *Dis. of the Chest,* **5**:2, 1939.

DISCUSSION

From the foregoing study certain impressions emerge, as follows:

1. The "black spores" of Ross and Grassi, while apparently related to the malarial parasite, have never been satisfactorily explained, correlated with any known cycle of its development, nor dissociated from it.

2. The mosquito is an important factor in the spread of acute malaria, but the assumption that it is the only source of human malarial infection remains an assumption on a negative basis, and is questioned by the occurrence of congenital infections if not also by the natural history and the general success of an enterprising protozoan.

3. The sexually continent resignation to oblivion attributed to the malarial parasite within the human body rests upon a negative basis. It is questioned by various reported observations and is contrary to all expectations of natural history.

4. The malarial parasite is probably not strictly an erythrocytic parasite, and upon the basis of cultural studies and basic protozoology* [39, 40], it is likely that the oxygenated erythrocyte would be a most unfavorable site for its growth.

5. The malarial parasite by virtue of its achievements is worthy not only of respect but also of suspicion that it is a resourceful animal which might readily revert to ancestral type.

6. Historically, there is much similarity between the behavior of the infection in the Carolina lowlands and in Indiana.

7. As indicated both by history and by smear findings, P. falciparum infection was significantly common in Indiana.

8. Indiana was so thoroughly sold upon the inevitable disappearance of malaria as clearing and drainage progressed that no comment was aroused when the picture of malarial incidence changed from an average of 252 deaths per year in the decade before the "smear positive" criterion to an average of about 13 cases per year in the decade following its introduction. (Consequently it seems that in excess of 200 deaths per year and an inestimable number of non-fatal cases formerly considered malarial had to be apportioned under other classi-

* Oxygen may even be harmful to protozoans inhabiting the interior of other animals; thus flagellate commensals of the termite intestine can be killed without harm to the host by placing the host in a high oxygen atmosphere, (Hyman, 1940).[39] Definitely detrimental to in vitro growth of P. knowlesi is a gas phase high in oxygen content (Ball, et al., 1945).[40]

[39] Hyman, Libbie Henrietta: *The Invertebrates,* McGraw-Hill Book Company, Inc., New York and London, 1940.

[40] Ball, Eric G.; Afinsen, Christian; Geiman, Quentin M.; McKee, Ralph W.; and Ormsbee, Richard A.: In Vitro Growth and Multiplication of the Malaria Parasite, Plasmodium knowlesi, *Science,* **101**:542, (May 25) 1945.

fications of illness to avoid a not entirely imaginary penalty of professional stigma.)

9. Sporadic acute cases and epidemics still occur throughout the state, while the patient who cannot exhibit a classical parasite remains an imponderable quantity.

10. A seven- to ten-day clinical cycle apparently inexplicable in terms of the schizogonic cycle might be explained upon the basis of a sexual cycle of parasitic development in man.

Malaria is not a new disease, nor did scientific study of it begin with Laveran. The studies of Jones (1859)[41] occupying 404 published pages are excellent testimony thereof. So far as I know the Kodachrome reproductions in Upjohn's *Scope* (June, 1944) are the first such of plasmodia, but the 250 photomicrographs, including one plate in color, presented by Mary Rowley Lawson (1911)[8] stand alongside them in evidence that things are not always as they may be painted. It is safe to assume that neither set was accumulated in a moment of unconsidered enthusiasm. There is an interesting correlation between the publications of Joukoff[11] and Perekropoff[12] and the beginning date of World War I which may account in some degree for the scant consideration they received.

[41] Jones, Joseph: Observations on Some of the Physical, Chemical, Physiological, and Pathological Phenomena of Malarial Fever. *Tr. Amer. Med. Assn.*, **12**:211, 1859.

CONCLUSIONS

1. The introduction of the "smear positive" criterion in Indiana coincides with a reduction of malaria so remarkable that it could hardly have been conceived nor accepted without the preconception of its certain disappearance.

2. This preconception may well be an example of syllogistic fallacy.

3. The apparent reduction would suggest that:
   (a) The parasite of Laveran is responsible for only a small proportion of the disease long known as malaria; or
   (b) Our conception of its morphology, staining reactions, and life-cycle may be incomplete.

4. Critical review of the concept seems to point to the latter possibility in particular.

AMEBIASIS MASQUERADING AS PORTAL CIRRHOSIS

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Much has been written concerning the diversity of lesions associated with infection by Endamoeba histolytica. It has been stated by Berne[1] that abscess of the liver must always be antedated by infection of the colon, a point that had remained controversial until the end of the nineteenth century. According to Ochsner and De Bakey,[2] access of the amoebae to the liver may be gained by direct extension through the bowel wall, by the lymphatics, or by the portal vein. The abscess, usually single, occurs most frequently in the right lobe because of the selective drainage of blood from the superior mesenteric vein into this area. Given a case of amebiasis, the frequency with which the liver becomes involved is difficult to establish. Simonds[3] records 42.4 per cent from a group of 1,725 autopsied cases compiled from several authors. Councilman and Lafleur[4] give figures of 21.4 per cent among 1,429 cases in India, and 17.9 per cent among 1,001 cases in Algiers. These figures represent a high estimate, since the fatality rate of uncomplicated amebic dysentery is negligible. This is exemplified by data from Ochsner and De Bakey[2] in which were found 4.86 per cent among 9,696 clinical cases of amebiasis, and 36.6 per cent among 5,211 autopsied cases.

Early diagnosis of hepatic abscess may be obscured by lack of confirmatory symptoms. In a review of seventy-four cases, Berne[1] reports that only 41 per cent complained of antecedent diarrhea. The typical picture of an abscess is frequently absent, or this lesion may be clinically latent over a period of many years with subsequent reactivation. Once the liver has become the seat of an abscess, various complications may arise, pleuropulmonary involvement occurring most frequently, with contamination of the peritoneal cavity next in importance, according to Ochsner and De Bakey.[5] Perforation or extension into contiguous structures occasionally takes place. Dissemination by way of the systemic circulation occurs rarely; cases of cerebral abscess usually follow in the wake of hepatic or pulmonary invasion, although an exception to this rule is reported by Halpert and Ashley.[6] Mistaken diagnoses are frequently made because

[1] Berne, C. J.: Diagnosis and Treatment of Amebic Abscess, *S. G. and O.*, **75**:235, (August) 1942.

[2] Ochsner, A., and De Bakey, M.: Amebic Hepatitis and Hepatic Abscess, *Surgery*, **13**:460, 1943.

[3] Simonds, J. P.: Complications of Amebiasis, *Quart. Bull. Northwestern Univ. Med. Sch.*, (Spring Quarter) **17**:25, 1943.

[4] Councilman, W. T., and Lafleur, H. A.: Amoebic Dysentery, *Johns Hopkins Hospital, Rep.*, **2**:395, 1891.

[5] Ochsner, A., and De Bakey, M.: Amebic Hepatitis and Hepatic Abscess, *Surgery*, **13**:612, (April) 1943.

FIGURE I



Anterior surface of the liver.

of the protean manifestations of amebiasis. The following case of advanced amebic abscess was treated as one of portal cirrhosis, its true etiology having remained unrecognized until autopsy.

Case Report:

E.W.T., a forty-one-year-old carpenter, was admitted to the Robert W. Long Hospital, March 23, 1943, because of tenderness in the right upper quadrant, fluid in the abdomen, and weakness. The onset of his illness was in September, 1942, with dull pain below the right costal margin, accompanied by chills and fever. A tentative diagnosis of malaria had been made by the local doctor, and he was given quinine with no relief. The pain persisted, and there was a gradual loss of appetite, with nausea, and frequent vomiting; by December he had restricted his diet to liquids. In January, 1943, he noticed that his abdomen was increasing in size, and by the last of February he required a paracentesis, which procedure was repeated three times before his hospital admission. His weakness had been progressive, and he recalled a recent diarrhea consisting of three to four stools a day. His past history was irrelevant except for the fact that he had been a heavy drinker of whisky for the past year and a half.

Physical examination revealed an emaciated and dehydrated man with a temperature of 98.2F, pulse of 104, and blood pressure of 106 systolic and 86 diastolic. The tongue was slick and red, and several spider naevi were scattered over the face and upper thorax. There was no demonstrable evidence of pulmonary or cardiac disease although the diaphragm was abnormally elevated on the right. There was tenderness over the epigastrium, but palpation of abdominal organs was impossible because of pronounced distention with fluid; the skin was dry and tense, and the veins about the umbilicus were prominent. Large internal hemorrhoids were present, and there was bilateral inguinal adenopathy.

Laboratory data revealed that the urine had a trace of albumin, 2 to 4 pus cells, and gave a positive test for bile and urobilinogen. The blood showed a hemoglobin of 11 grams, 2,780,000 erythrocytes, and 12,700 leukocytes with a normal differential. The blood serology was negative, sedimentation rate 36 (Wintrobe method), and total serum proteins 6.0 grams per cent with albumin 1.9 and globulin 4.1. The direct van den Bergh was positive and indirect 0.8 mg. of bilirubin. The prothrombin time was 117 per cent of a normal control; the bromsulfalein test showed 90 per cent of the dye present in twenty-five minutes, and 70 per cent after one hour. A stool examination was positive for blood. Roentgenogram revealed no parenchymatous pathology of the lungs although there were compression changes in the right base, and the right leaf of the diaphragm was elevated. Following oral administration of dye, the gall bladder failed to visualize, and no biliary tract stones were seen.

The patient received supportive treatment and a paracentesis performed on March 26 produced 10 liters of clear, straw-colored fluid having a specific gravity of 1.010 and 1.2 per cent protein. Following removal of the ascitic fluid the liver was readily palpable three fingers below the costal margin, and presented a firm, nodular border. He failed to improve, and on April 11 an icteric tint to the skin was detected and crepitant rales could be heard in both lung bases. From a second paracentesis on April 14, seven liters of a transudate were obtained. He became increasingly more lethargic, and died on April 18.

Autopsy Report:

The lower portion of the lungs, posteriorly, were firm in consistency, that on the left showing nodules which contained pus, on section. The quadrate and left lobes of the liver were atrophic (Fig. I); the

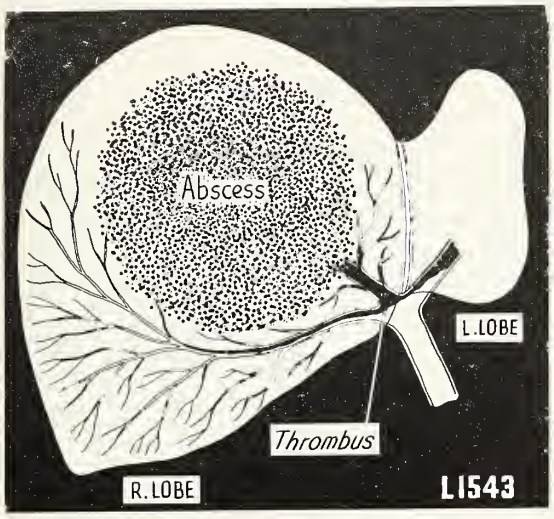
FIGURE II



Section through the abscess.

[6] Halpert, B., and Ashley, J. D., Jr.: Amebic Colitis Complicated with Abscess of the Brain, *Arch. Pathol.*, **38**:112, (August) 1944.

FIGURE III



Diagrammatic representation of thrombus.

right lobe showed a dome, fluctuant to touch, from which thick, wine-colored fluid was aspirated (Fig. II). The main branches of the portal vein and a radicle of the hepatic vein to the right lobe of the liver were occluded by thrombotic material as they entered the wall of the abscess. The shell of remaining hepatic tissue was receiving a depleted blood supply from a few smaller proximal branches. The main branch to the left lobe was likewise thrombosed (Fig. III). The lower liver margin was irregular and bosselated. The enlarged spleen weighed 750 grams. Demonstrable lesions in the colon were confined to the ascending portion, distal to the ileocecal valve. Here were found undermined ulcers, ranging in size from pin point to two centimeters in diameter.

Microscopically, the wall of the liver abscess was comprised of chronic granulation tissue with infiltration of polymorphonuclear leukocytes. The surrounding area was compressed by young connective tissue into portions of which were proliferating bile ducts. In the large bowel the ulcers had perforated the muscularis mucosae. Examination of the debris from the liver abscess and from these ulcers revealed sharply-outlined oval cells morphologically recognizable as Endamoeba histolytica.

Summary:

This case is cited as presenting a previously-unreported complication of amebiasis, namely, portal obstruction with ascites. On admission, this patient presented a problem suggestive of advanced cirrhosis of the liver, and there was little to cause one to suspect a terminal amebic abscess. Reviewing the course of his illness, in retrospect, it becomes apparent that his early symptoms were those of a liver abscess, and that this lesion had increased in size, gradually destroying the major portion of the right lobe. Branches of both portal and hepatic veins were encroached upon, finally resulting in thrombosis and a typical picture of portal obstruction.

ABSTRACT: NEW DRUG HAS DRAMATIC EFFECT UPON PATIENTS WITH EPILEPSY

A new drug, tridione, is destined to remove the blighting effect of epilepsy on the normal growth and education of many children, according to William G. Lennox, M.D., Boston.

Writing in the December 15 issue of *The Journal of the American Medical Association*, Dr. Lennox, who is associated with the Department of Diseases of the Nervous System, Harvard Medical School, and the Children's Hospital, said, "Tridione, in my experience, has been the most dramatic in its effect of any form of therapy attempted." Out of forty patients, eleven, or 28 per cent, were freed from epileptic seizures; twenty-one, or 52 per cent, experienced a 75 per cent or greater reduction in the number of seizures, and ten, or 20 per cent, were helped moderately. Treatment was discontinued in two cases. The author stated that "none failed to experience some amelioration of seizures."

Disappointing results have usually been derived from previously-accepted treatments. Some were effective in giving temporary or partial assistance in the control of epilepsy, but none equaled tridione in its action. This drug abruptly decreased or wiped out the seizure in a period of days or weeks, and after only temporary treatment it produced lasting effects in some cases.

There are three types of seizures which the author says "are most likely to benefit from this new medicine." The first, petit mal, is a transient lapse of consciousness; the second, myoclonic epilepsy, is a single, quick contraction of muscles; and the third, akinetic epilepsy, is a sudden loss of postural control.

According to Dr. Lennox, these seizures have a number of characteristics in common, "great frequency, brevity of attacks, abrupt onset and termination, maintenance of mentality. . . ." It has been the author's experience that "patients with pure petit mal seem unusually bright."

Since the effect of tridione treatment of epilepsy is still being investigated, it is not yet on the market. Some unpleasant side effects have been noted, namely a skin rash and an unusual sensitivity of the eyes to bright daylight. The author added, however, that pleasant reactions included an improvement in appetite and gain in weight by some patients. "In others the disappearance of clinical symptoms has been marked by an improvement in the school performance or in the deportment of the child."

Recently, the author was instrumental in devising methods for recording the electric disturbances that constantly occur in brain and nerve tissue. These records are known as electroencephalograms. In normal people these records show rhythmic waves with certain variations; in the epileptic there are definite changes from these both in rate and amplitude of electrical disturbances. For example, the petit mal form of epilepsy shows an alternating fast and slow rhythm. The electroencephalogram is now being used in the diagnosis of epilepsy. From the studies made a new definition of epilepsy has been derived—it is an expression of the improper functioning of the rhythm-regulating mechanism of the brain.

CASE REPORT OF CONGENITAL APLASIA OF THE PYLORUS

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LAFAYETTE

This report is of particular interest at this time because of the extreme rarity of the congenital condition and because a review of the literature did not disclose any such case having been heretofore reported. It is additionally important because such alterations in fetal development always interfere with the normal functioning of the small bowel and inevitably lead to serious conditions of the abdomen.

The infant's mother was thirty-seven years of age at the time of this birth, Para I, Gravida I. Her past history showed that she had an appendectomy in 1941 and a left salpingectomy and left oophorectomy in 1943. She had had no other serious illness. Her serology was negative. There was no history of any falls, nausea, nor edema during her prenatal care. The blood pressure remained normal, and the urine was negative throughout her prenatal period. The patient's paternal history was essentially negative, as was that of the grandparents on both sides.

The mother had a normally spontaneous delivery, left occipital anterior position, after eight hours of active labor, on July 31, 1944, and the baby weighed 5 lbs., 5 oz. at birth.

Physical examination after birth: The baby began to cry soon after delivery; its color was good; examination of the chest revealed no pathology; the heart was normal; and the extremities were normal. A few hours after delivery it became cyanotic; and at this time a slight distention of the abdomen was noted, as also were some small red patches over the face, abdomen, and anal region. The baby vomited some brownish material streaked with bright red blood. Fifteen cubic centimeters of whole blood, from the father, was transfused into the buttocks of the baby, and oxygen was administered continuously by nasal catheter. Fifty cc. of normal saline with 1 per cent glucose was given to the baby by hypodermoclysis twice daily. The following day the baby's respiration had improved, and its color again appeared normal. The abdomen still was greatly distended. Stomach lavage was ordered, and a large amount of thready pieces of blood and yellowish fluid was obtained. Hemorrhagic spots were present over the face and body. Marked jaundice appeared at this time. The baby had carried no elevation of temperature. Later, on this second day, the abdomen again became distended, and there was a marked muscular rigidity above the umbilicus. The stomach again was lavaged, old blood clots and a brownish-yellow fluid being obtained. When three days old the baby vomited a large amount of brownish fluid, some exiting from the nose. He then became quite cyanotic and respiration ceased temporarily. Artificial respiration was carried out and oxygen given continuously. Respiration shortly was resumed, although it was labored and harsh. The stomach again was lavaged, and a large amount of brownish fluid with a foul odor was obtained. Later in the morning the baby's condition appeared to be improved. Its temperature now was elevated to 103.2 at 8:00 A.M., and his weight was 5 lbs. 2½ oz. The baby voided at this time, the first since birth. Later in the day the temperature again was normal. At this time 15 cc. of whole blood was given. The stomach again was lavaged, and the washings returned clear. On the fourth day the baby continued its shallow breathing, with vomiting at intervals. During this period it passed meconium for the first time since birth. The baby was taken to the breast for the first time and nursed well. Thirty minutes after it was returned to its crib it had projectile-type vomiting. On the fifth day the baby weighed 4 lbs.. 15 oz. The abdomen was not distended. He refused to nurse at the morning feeding, but nursed well at twelve o'clock, noon. Three hours later the projectile-type of emesis again occurred. When six days old the baby appeared weaker, with some cyanosis present. He continued to vomit when given water. A barium meal was given, and the stomach was x-rayed.

X-ray findings: The heart, lungs, and mediastinum were normal. The stomach was greatly distended, but there was no gas in the colon or in the ileum. Barium was given by means of a stomach tube, and the stomach was fluoroscoped. For a short time deep stricture developed across the media, but it remained as a spastic constriction. No barium passed through the pyloris, and the film was repeated at the end of one hour. Other films were made at four and eight hours, and it was observed that no barium exited from the stomach. The following day another film was made after the stomach had been aspirated by a stomach tube. At that time a trace of barium remained. None had passed. Diagnosis: Complete pyloric obstruction.

Following the x-ray examinations the stomach was lavaged to remove the barium. Atropine 1-1000 was given every four hours without therapeutic result. The abdomen remained distended, and the baby continued to vomit. No abdominal mass could be felt. After giving the baby a bottle of water and observing the abdomen, visible peristaltic waves were present, the first noted since birth. Later in the day I repeated giving the baby water and watched for peristalsis. It again occurred. Surgery was decided upon from the following facts at hand: presence of visible peri-

stalsis, left to right; projectile-type vomiting, and the x-ray examination.

In the differential diagnosis of pyloric obstruction the symptoms usually do not appear until from ten days to two weeks after birth. The vomitus does not contain bile, and in simple pyloric stenosis a tumor is usually palpable. The site of intestinal obstruction in infants is noteworthy. Of the statistics checked, about 30 per cent are found in the duodenum at or near the ampulla of Vater. The second most frequent site is at the duodenojejunal junction; and next, at the vittelline duct. The remaining cases are scattered along the jejunum or the ileum.

In preparation for surgery the baby was given 50 cc. of saline with 1 per cent glucose, this by hypodermoclysis. He was also given 20 cc. of whole blood. The stomach was lavaged with a 5 per cent solution of soda water, and the clotting time was taken and found to be three minutes. The blood count was as follows: red cell count, 3,700,000; white cell count, 11,350; hemoglobin, 70 per cent; neutrophils, 75 per cent; bands, 5 per cent; lymphocytes, 19 per cent; and monocytes, 1 per cent. The baby was operated upon under ether anesthetic. The abdomen was prepared with ether and tincture of merthiolate. An upper right rectus incision was made, starting just below the rib margin. The incision was made here because the liver is low in infants, and when the incision is closed the liver serves as a cover under the incision and helps prevent both adhesions and hernias. The stomach was located, but I was unable to palpate the pylorus. An incision was made into the anterior wall of the stomach as an exploratory measure. No pyloric opening was present. The duodenum was located, and there was an absence of about two centimeters of intestine at the pylorus. After careful examination of the intestinal tract, an anterior gastrojejunostomy was performed, using No. 5-0 chromic catgut. The incision was closed with No. 0 chromic to the peritoneum, chromic to the fascia, and chromic to the skin. The baby was returned to its incubator in fair condition. Fifteen cc. of plasma was given intramuscularly. Fifty cc. of normal saline and 2½ per cent glucose was given by hypodermoclysis twice daily. One thousand units of penicillin was given every three hours. The patient had a mild postoperative course the first forty-eight hours, without vomiting. Then he began to run a septic temperature, and fine rales could be heard over the chest. Coughing developed and breathing became labored. On the fourth postoperative day the baby died. Autopsy revealed acute bronchial pneumonia and an early beginning of an inflammatory peritonitis.

The cause of the intestinal obstruction was probably due to a defect in the embryological development of the lumen of the bowel. Tendles has shown that in the fifth week of embryonic life the small bowel is filled with an epithelial proliferation, so that the structure is a solid cord. At the end of the second month vascularization occurs with canalization to form the peritoneal bands. In congenital obstruction of the bowel three types of occlusion are found: one, stenosis, in which there is a partial obstruction of the lumen; two, atresia, where there is complete obstruction; and, three, aplasia, in which there is a complete obstruction due to the entire absence of a segment of the bowel. The bowel above the side of the obstruction is dilated, usually having small or massive hemorrhages from the mucous membrane. The bowel below the site of the obstruction is smaller.

CONCLUSION

The points most outstanding to me in this case are: first, the rarity of the condition; second, the diagnostic problem it presented; and third, the surgery involved.

ABSTRACT

UNDULANT FEVER

Brucella melitensis, the cause of undulant fever which is prevalent on the Mediterranean coasts, has been found regionally in Iowa, according to two doctors writing in the January 12 issue of *The Journal of the American Medical Association*. Different forms of the disease have been recognized in cattle and hogs in Iowa since 1927, but during the last two years twenty infected patients are known to have acquired it in this state.

The report was presented by Carl F. Jordan, M.D., director of the Division of Preventable Diseases, and Epidemiologist, Iowa State Department of Health, Des Moines, and Irving H. Borts, M.D., director of the State Hygienic Laboratory, Iowa State Department of Health, and assistant professor of hygiene and preventive medicine, State University of Iowa College of Medicine.

Goats, cows and hogs harbor the infection, and man contracts it by drinking raw milk or handling infectious material. Man is easily infected, but the pasteurization of milk undoubtedly has been responsible for greatly restricting the disease.

Of the twenty patients studied between 1943 and 1945, ten were packing-house employees and the rest were farm workers, farm residents, or visitors.

The doctors said that the infection was characterized by fever, chills or chilliness, sweating, weakness, loss of weight, headache, muscular pains, and leg pains. In several cases they also noted a rash, nosebleed, glandular swelling and nasal ulcerations.

The study led the authors to conclude that hogs are probably the major source of infection. "It is probable that Brucella melitensis has been introduced into Iowa during the past decade, and that this species of Brucella has been transmitted to hogs from sheep imported originally from western and southwestern sections of this country."

A CASE OF COARCTATION OF THE AORTA (ADULT TYPE) WITH THE WOLFF-PARKINSON-WHITE SYNDROME

ROBERT M. MOORE, M.D.*

GREY DIMOND, M.D.**

INDIANAPOLIS

The occurrence and recognition of coarctation of the aorta and the Wolff-Parkinson-White Syndrome in one patient has not been reported previously. We have recently seen such a case and considered it unusual enough to merit recording in the literature.

CASE HISTORY

W.T., a fifteen-year-old white boy was admitted to the James Whitcomb Riley Hospital for Children on August 9, 1945. His parents stated that he had "a rheumatic heart and chorea." Careful questioning regarding this statement revealed that at the age of six the boy was discovered to have a heart murmur. This had been interpreted as being due to rheumatic fever. He had been carefully sheltered and overzealously observed since that time. Five years prior to admission, at the age of ten, the boy had developed a twitching in his facial muscles which, during the following year, had progressed to involve his entire body. These movements were not the characteristic purposeless movements of Sydenham's chorea, but were jerky, convulsive movements of entire muscle groups. They did not interfere with eating or writing. They stopped during sleep.

The boy was well-developed, very alert, and cooperative. There was no history of joint pain, scarlet fever, nosebleeds, abdominal crises, et cetera.

Physical examination revealed the peculiar erratic twitchings described above. Prominent pulsations were seen in the neck vessels. In the supraclavicular fossae definite bruits could be heard and thrills felt. No thrill could be felt over the precordia. The apex thrust was increased and slightly to the left of the mid-clavicular line. A rough, loud systolic murmur was maximal in the third and fourth left interspace. No diastolic murmurs were heard. The murmur could be heard equally well in back. No pulsations, thrills, or bruits could be identified over the back.

The blood pressure on admission was 160/100 in the right arm; on subsequent examinations it was found to be 140/100-90 in both arms. No abdominal, aortic, femoral, popliteal or dorsalis pedis pulsations could be felt. No blood pressure could be obtained in the legs. No clubbing was present.

X-ray studies of the heart revealed a large left ventricle, very small aortic knob, and the shadow of the descending aorta could not be seen. (Figure I). Although suspicious grooving of the ribs was made out, no typical rib-notching was seen.

During an attempt to obtain an electrocardiogram the patient became very excited and developed a sudden rapid heart beat. The tracing taken during this time was interpreted as paroxysmal auricular tachycardia (Figure II). Upon being questioned, the patient stated that since earliest childhood he had had these episodes of sudden, rapid heart action, which would cease equally as suddenly.

A subsequent tracing after the attack had stopped revealed an abnormally short P-R interval (.08 sec.), with a widened and bizarre QRS complex (Figure III).

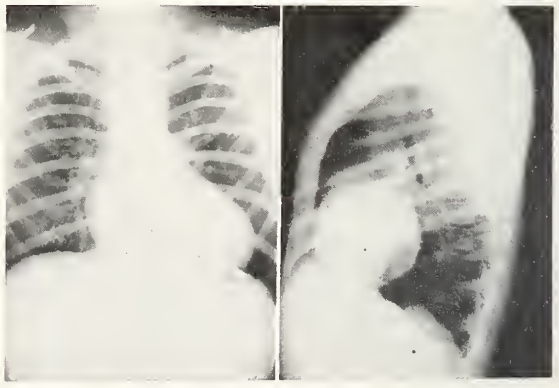
Other laboratory studies were essentially negative.

The final impression was that this patient probably had a coarctation of his aorta and an unrelated Wolff-Parkinson-White Syndrome. The jerky, spasmodic movements were thought to be an extreme habit tic or spasm.

DISCUSSION

The diagnosis of coarctation of the aorta is being made with an ever-increasing frequency as clinicians become more aware of the entity. In patients with hypertension, especially young people, coarctation should be considered. The typical findings are an increased pressure in the arms, particularly systolic pressure, and a diminution or complete absence of

FIGURE I



Teleoroentgenogram, left lateral.

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FIGURE II

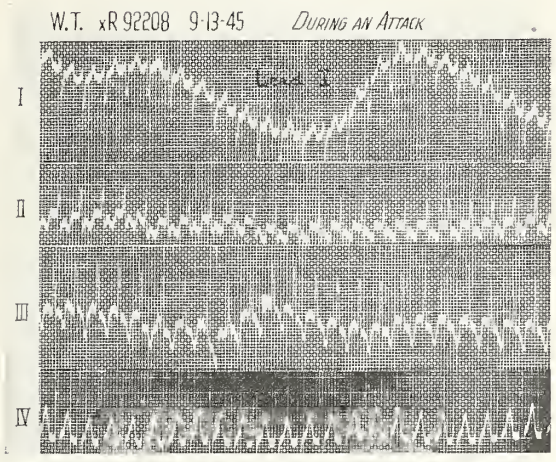
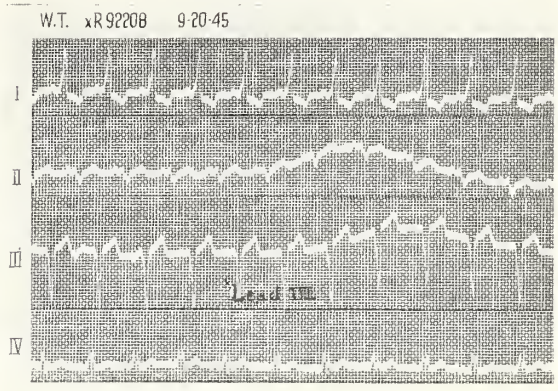


FIGURE III



pulsations in the abdominal aorta, femorals and dorsalis pedis. No constant type of murmur is described, but in general one hears a loud, rough, systolic murmur over the entire precordium, maximal near the base of the heart. This murmur can be heard equally well in back. Evidence of collateral circulation, such as dilated and tortuous vessels with a palpable thrill, found over the back, chest, and in the neck is an important finding.[1, 2]

Rib-notching was not present in this case. We do not believe that this is evidence against the diagnosis. Fray[3] stated that rib-notching is not a constant finding. He believed that the notching depended upon the degree of the stenosis and the age of the patient. He further stated that the aortic intercostals must be involved in the anastomosis if rib-notching is to be present, inasmuch as it is their eroding action which produces the grooving. If the primary route for the blood flow was through the subclavian arteries and then into the internal mammaries and these joining with the inferior epigastric vessels, dilatation of the intercostal vessels might be minimal and notching absent.

The diagonsis of Wolff-Parkinson-White Syndrome in this patient rests upon the tracings which presented a short P-R interval and a widened QRS complex. We were fortunate in obtaining a tracing during one of his paroxysmal attacks. The Wolff-Parkinson-White Syndrome occurs primarily in normal hearts.[4,5] The patients are as a rule in good health, and their only complaint is that of having episodes of palpitation.

Although there is organic heart disease present in this case, we believe the two entities are not causally related to each other. It is interesting to hypothesize if the correct diagnosis would have been made if this patient had been seen for the first time at the age of forty-five or fifty. One can see how easy it would be to make a diagnosis of essential hypertension and interpret the electrocardiographic findings as a left bundle branch block and evidence of cardiac damage.

SUMMARY

We have presented a case of coarctation of the aorta, from whom we also obtained tracings which are typical of the Wolff-Parkinson-White Syndrome. We consider their relationship coincidental and not causal.

[1] White, Paul: *Heart Disease,* 3rd Edition, p. 304, 1942.

[2] Levine, Samuel A.: *Clinical Heart Disease,* 3rd Edition, p. 173, 1944.

[3] Fray, Walter: The Roentgenological Diagnosis of Coarctation of the Aorta, *Am. J. Roentgenol.,* Vol. 24, p. 349, 1930.

[4] Wolff, L.; Parkinson, James; and White, Paul D.: *Am. Heart Journal,* Vol. 5, p. 685, (Aug.) 1930.

[5] Movitt, E. R.: *Am. Heart Journal,* Vol. 29, p. 78, 1945.

ABSTRACT: NICOTINIC ACID RELIEVES PATIENTS WITH SEVERE HEADACHES

Two New York physicians, writing in the May 11 issue of *The Journal of the American Medical Association,* report that nicotinic acid is highly effective for the relief of headaches of a persistent nature, such as migraine or severe idiopathic headaches which stem from an unknown cause.

Joseph W. Goldzieher, M.D., and George L. Popkin, M.D., from the New York City Hospital, Welfare Island, say that of one hundred consecutive patients with severe headaches who received injections of nicotinic acid, seventy-five were completely relieved.

The patients had 100 milligrams of nicotinic acid in a salt solution injected into their veins. This was the standard dosage. In the average case from thirty to forty-five seconds elapsed before the patient was aware of any effects, the doctors write. Then there was a feeling of warmth or heat with an accompanying flush. "Within three or four minutes the patient, though not comfortable, became accustomed to the heat, which gradually subsided in about fifteen minutes and usually disappeared in twenty minutes to a half hour."

Nicotinic acid is a nutritional factor of the vitamin B complex, used in the treatment of acute pellagra—a vitamin deficiency disease. It is known to produce a dilatation of the blood vessels with an increase of blood flow to the brain.

Nicotinic acid has also been known to relieve malarial headache and sinus headache.

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JULY, 1946

Editorials

FULL-TIME COUNTY HEALTH OFFICERS

"Full-time County Health Officers" should be one of the primary planks in the platform of the Indiana State Medical Association; we know of nothing more important just at this time. We have gone along for a good many years under the old system, a system in which the local county commissioners usually appoint some physician to be county health officer—all too often this appointment is made on a political basis.

We recall when the chief job of such an officer was to collect data on births, deaths, and certain of the communicable diseases, but little else was required. On rare occasions the officer was called upon to inspect some country school building, with a view to condemning it. This came about in the latter years of the regime of Dr. John N. Hurty, then secretary of the Indiana State Board of Health.

Today the job is, or should be, a big one, big enough to demand the full time of the officer. And just now would seem to be the time to put the deal over; Hoosier folk are rapidly becoming health conscious. They know a lot about infantile paralysis; they know that diphtheria is a controllable disease; and they are learning that tuberculosis is in a fair way to be absolutely controlled. A judicious amount of propaganda in matters pertaining to health, and what we can do to promote this health in a higher degree, will do wonders. As we repeatedly have said, the state administration is health-minded and will aid materially in any such program as is advanced by the Indiana State Medical Association.

STATE HOSPITAL NEEDS

For a long time Hoosier folk have been aware of the crying need for additional hospital facilities for the mentally ill, and at long last a new hospital is in the offing, which also is planned to take over the criminal insane from the Michigan City prison. The trouble with most of us is that we get to talking about some such need and then overlook other needs that are just as urgent.

For years most of us have known that Indiana has an "Epileptic Colony" near Newcastle; we knew that it was established and that along in May, 1906, Dr. Walter C. Van Nuys was named as its head. The good doctor moved into one of the farm houses on the tract of land that had been bought and proceeded to get things going. Several other old buildings on the site were utilized in one way or another, and later some small buildings of the "cottage" type were constructed. He continued to reside in the old house, whose timbers now have reached the age of one hundred years.

This is one of the institutions that, while it has done and is doing a very good job, is little known to our citizens. We well recall that prior to its establishment many epileptics were sent to our insane hospitals for medical care, there being no other place where they could be housed. Now they have adequate medical care, are well housed, and are supervised by one of the leading American authorities on epilepsy.

Like other state hospitals, improvements are needed there, and a new building would materially add to the success of the project, all of which should receive due attention at the next session of the Indiana General Assembly.

As the reader knows, there is no bonded indebtedness in Indiana. The state goes on a "pay as you go" basis; hence, appropriations must be made by the biennial legislature ere new work can be begun or repairs made to existing buildings and grounds. Our institution at Butlerville is rather new and the needs there for additional building are not so great, but other state hospitals are not so fortunate. The erection of the new hospital for mental cases will materially relieve the case load at the five hospitals now in operation, the new

Evansville State Hospital already being a great help in this direction.

But there is much that needs to be done, some of it of the *must* variety, and it is hoped that the next legislature will keep these things in mind.

A REPORT ON "HEALTH AGENCIES"

The Metropolitan Life Insurance Company, for years one of the most outstanding advocates of improved health conditions, has issued a very interesting and factual brochure, "What Ails Our Voluntary Health Agencies?" This report is written by Louis L. Dublin, second vice-president and statistician of the company. It is in no sense a tirade against the ever-increasing number of health agencies over the country; rather, is it an interpretation of the official report recently issued by the National Health Council, this report being made after an exhaustive study of all phases of the "health agency" problem.

In 1941, chiefly through financial aid from the Rockefeller Foundation, the council began a survey, under the direction of expert investigators, this being carried on over a period of more than three years. Twenty-nine states were visited, and some sixty-five cities over the country were checked, more than five hundred voluntary agencies having been investigated.

As a result of these investigations it is now possible for the American people to know just what is being done with the dollars they annually contribute, via way of "drives, special weeks, and months" and through personal solicitation. Among the outstanding charities reported on are the American Red Cross, the March of Dimes, Cancer Prevention groups, et cetera.

Some most interesting facts have come from these studies, a notable one having to do with tuberculosis. As a result of the activities of the National Tuberculosis Association, that disease has long since been displaced from "leadership," and now occupies eighth place in the list of causes of death in this country.

There is no gainsaying the fact that these organizations, for the most part, have done and are doing a heroic work, but as Mr. Dublin remarks, "But our report also discloses serious shortcomings. It would be a grave disservice to the health movement if through silence or equivocation we helped to lull its supporters into complacency. The study which has indicated the virtues and contributions of our voluntary health work has also disclosed that much needs to be remedied. *The very freedom and spontaneity with which the volunteer societies have sprung up is also the source of their greatest weakness.*" (Italics ours.)

The writer also complains about "specialization" by many of these groups; they attack but one phase of the health problem, leaving other considerations to other voluntary health groups. This, of course, makes for much repetition—a single organization might well take over many other health problems. It is his opinion that, "obviously, such haphazard generosity cannot continue as a permanent program. The inevitable result of such multiplication of societies is the impoverishment of each, competition for support, and the confusion of the public."

We long have recognized that in too many instances, even in our smaller cities, there are too many organizations trying to do the same thing. For example, take the matter of nursing, in some communities there are several organizations of the voluntary type that are doing "Public Health Nursing." It is the opinion of the investigating committee, this opinion being supported by the National Organization of Public Health Nursing, that the small nursing groups be combined into a single organization. This, of course, would result in a marked improvement in the services rendered, also would result in an increased budget, for when there are too many calls for financial help in this field, Mr. and Mrs. John Q. Public soon become inclined to throw up their hands and say, "Oh, what's the use; we cannot give to all these groups!"

Again does the committee comment on the failure of some of the voluntary health groups to recognize changes which have come about in the communities in which they operate—"the fine enthusiasm of the pioneers who organized to meet a serious health problem has in some instances degenerated in the course of years to an effort to preserve their institution intact rather than to serve a public need."

The committee seems to be pretty well agreed —in which opinion many members of the National Tuberculosis Association are in accord—that "the tuberculosis problem has been largely solved in the United States as a whole," and that now the big problem is how to best spend the several million dollars of annual income of the association. Christmas Seals sales annually bring in some fifteen million dollars, and the sales increase every year. But five per cent of the proceeds from these sales goes into the national treasury, the remainder being distributed to state and local societies.

Then, too, the committee finds that state and local health departments have taken over much of the work formerly done by the voluntary groups, and that there presently is not the need for so many of the latter organizations.

The committee further feels that perhaps too much attention is given to some of the more "spectacular" diseases, such as infantile paralysis, and too little to the greatest of the "killers," heart disease.

The article by Mr. Dublin goes on to mention many other inadequacies, many other things that in the opinion of the investigating committee could well be changed, with much benefit, but the whole article is based on the belief—the finding of this committee—that there is too much duplication, too

much specialization in many of the fields occupied by many of these voluntary health organizations, and that something should be done to regulate them better.

Thus is opened up a subject that has been of interest to medical men for many years, and it is hoped that due publicity will be given to the report of the three-year study by an expert committee.

A WELFARE ANALYSIS

Some weeks after we had written the editorial regarding an official report on welfare and health organizations, appearing in another column, Rollis S. Weesner, executive secretary of the Lake County Medical Society, told us he had prepared an article on this subject for publication in the May issue of *The Lake County Medical News*.

Mr. Weesner has intimate knowledge of this subject, since most of his adult life has been spent in such work. For many years he was attendance officer in the local schools, served on the board of the local chapter of the American Red Cross, on the board of the Lake County Tuberculosis Association, on the board of the Hammond Community Chest, along with divers other similar connections. He knows exactly what he is talking about and writes his ideas in an entertaining, informative manner. His comments are published herewith:

CAN PHYSICIANS HELP HEALTH AGENCIES MAKE THEIR PROGRAMS MORE EFFECTIVE?

A generous public in Lake County this year has contributed as follows to:

The Tuberculosis Association	$48,000
The Infantile Paralysis Foundation	30,000
The American Cancer Society	15,000
The Crippled Children's Society	12,000

More than $100,000 was contributed in the belief that their money is helping their fellow men in the control and eradication of disease and misfortune!

What becomes of this money?

TUBERCULOSIS

The Tuberculosis Association, the oldest and strongest of these private aid societies, sends 17 per cent of its yearly collection to state and national offices. On these levels, broad policies of program and supervision are maintained with money appropriated for general research, experimentation, and education. The association on no level actually cares for the tuberculous patient.

Our own association in Lake County maintains offices in Gary with a full-time secretary and staff, including a visiting nurse, librarian (working in the sanitorium), health educator, and clerical help necessary primarily to conduct the yearly sale of Christmas seals which finances the program.

The sale of TB Seals at Christmas time is a unique method of raising funds and is very successful, although expensive, since work must be done the year around in checking names, preparing mail, etc. The public, however, is relieved of personal bother that characterizes the usual method of "drives" for charitable purposes.

The primary return in service to the donating public should be education. This return has been good insofar as it has gone, and the association hopes to increase its effectiveness in this major field. The purchase of x-ray equipment now on order is a real contribution to the case-finding program recommended by the Lake County Medical Society, under the direction of Dr. Becker. Other help can be expected when this program gets under way.

Generous response in the last few years has made possible a neat balance in the resources of The Tuberculosis Association, making possible extended programs and possibly new adventures.

INFANTILE PARALYSIS

Emerging from its formative years, when motives could be questioned and organization was loose, has come a Lake County chapter of the National Infantile Paralysis Foundation with a governing board and a program that is basic and understandable. It is actual hospitalization, with nursing and therapeutic care and provision of prosthetic aids to victims of polio. This program is carried out at the St. Catherine's Hospital and is under the watchful eye of Dr. J. J. O'Connor.

One-half of the March of Dimes total goes to the national foundation, which in turn maintains offices at the state level to promote drives and services, and generally coordinate activities. Nationally, the foundation allots money for research and education and maintains some centers, notably the one at Warm Springs, Georgia.

CANCER

The American Cancer Society has promoted tag days, bottle collections, etc., in recent years, and all money obtained has gone to the national society. The Women's Field Army, which has aided this cause, was only concerned in raising money since there was no program locally for the expenditure of funds.

This year, however, a Lake County branch has been set up and under the organization rules 60 per cent of the money collected may be retained by the county, provided a program for the use of the money is created. This program may be research, diagnosis, educational scholarships, public information, and the like. The local branch wants to keep some of this money here and is depending on the medical profession to help them in creating worthwhile local use of funds in the fight against cancer.

CRIPPLED CHILDREN

Added to the growing field of "health agencies" now comes the Lake County Society for Crippled Children, a unit of the Indiana Society for Crippled Children, which has been selling Easter Seals through the mail for many years. Last year $8,000 was sent directly to Indianapolis from Lake County in self-addressed envelopes. By organizing a local society and increasing the mailing list and publicity, this sum has been raised this year to $12,000, of which $6,000 will remain in the county.

The promotion of aid to crippled children is one of the oldest of man's benefactions. Many programs for children have been carried out for years, notably the Shrine hospitals, Rotary, Kiwanis and other service club programs, Riley Hospital, erected by private subscription, and now a seemingly full coverage by the Public Welfare Department. Probably in no field has the medical profession itself contributed so much.

The local society proposes to employ bedside teachers who will carry public education to the crippled child who cannot attend school. This service will be limited essentially to the rural and town areas since the city school systems already provide bedside teachers for shut-in pupils.

UNIFICATION NEEDED

After state and national drives are cared for, we still have around $65,000 this year, not including surpluses, in the hands of these associations for combating tuberculosis, cancer, polio, and problems of crippled children.

Those responsible for the expenditure of these funds agree that general health and health education is basic, and that any program that helps general health helps

their specific problem. The Council of the Lake County Medical Society has approved the idea of a general health education program and is willing to sponsor jointly a broad program that would also include subjects not now covered, as well as emphasize those hazards for which the money was primarily given.

The executive secretary has been empowered to negotiate with and, if possible, develop a coordinated program that will not take anything away from the associations, but will coordinate and strengthen an over-all public information and educational service to make the public conscious of the good use its money is being put to, as well as increase knowledge on how to keep well.

NOT BUTTING IN

Doctors are members of every one of these boards. Lay people who operate or initiate programs are constantly warned by state and national heads to consult and follow the advice of their medical societies in the promotion of their work.

It is true that local doctors sometimes disapprove of national programs as they affect their local situation, but more often the doctor is just apathetic and the lay people go ahead assuming that what they are doing is good and correct.

People are genuinely interested in their health, and many serving on health organization boards or soliciting teams want the doctor to be a real part of their efforts. It's a public service for which nobody gets paid except by the feeling that a real service is being rendered. Lay people do not have this feeling when the doctor is absent.

TYPE OF PROGRAM

A unified program may take one of three courses: (a) a portion of funds from each agency turned over to the medical society for health education, the society employing personnel and assuming responsibility for an adequate and beneficial general health program; (b) coordination of work and purpose of each agency through the society as a clearing house, efforts to be synchronized to avoid duplication, cut expense and assure wide coverage; (c) establishment of a county health council made up of representatives of each agency, including public agencies that would assume control of the program.

CONCLUSIONS

Four fund-raising and administrative private health agencies now exist in Lake County. Each has a state and national organization back of it. They are in competition to collect and then do good with John Q. Public's dollar.

Their boards are made up of fine people. Some are interested in the purpose of the agency. More are there because their names add dignity and make collections easier. Others are good meeting attenders. They are, nevertheless, good citizens. They are honest and want these endeavors to be successful. It's the American way.

More importance is placed on getting the money than on how it is used. Each year's chairman must raise more money than his predecessor or he is disgraced. Social organizations, such as sororities, are coming into the field, making these drives "projects."

PUBLIC IS PUZZLED

The public is a bit bewildered but actually doesn't complain. The emotional appeal touches the heart and the propaganda of the drive is actually providing at present the bulk of their education in these fields.

Local people are not much concerned in these promotions from the job angle, but state and national executives are, and will keep things pepped up.

The amount of money raised bears little relationship to need in the general field. Polio is a good example of this. It is, however, encouraging that such interest has been aroused, and we may expect other fields to have their day.

HOW LONG WILL IT LAST?

How long the public will contribute and how many separate efforts it will support we do not know. Neither do we know how long a jealous government can refrain from taking over. It does seem sensible, though, to get together now on a program of service, especially education that will combine resources, broaden the base, and give the contributor a greater return for his investment in better health.

The doctor can help. The medical society seems the logical focal point for coordination and direction. A demonstration by our society might answer a question that is in the minds of many people throughout the country.

Editorial Notes

The Indianapolis Medical Society has entered a protest against the continuation of the "war emergency obstetrical and pediatric care" of G.I. families. A Senate Bill extending these privileges is now being considered. We believe that the society is well within its rights in making such a protest; we all were in accord with the *emergency* features of the war program, but we cannot see why a continuation of the program is necessary at this time.

When the "small pox scare" reached Indiana, following several outbreaks along the Pacific Coast, plans were rapidly made for wholesale vaccinations; everybody was urged to attend to this little, but important, detail. Among other groups, the Indianapolis Medical Society immediately got into action and voted to assist in the program. Further, it advocated mass vaccinations in the industries and larger business houses, these, in the main, to be carried out by the physicians regularly employed by these institutions. However, it also was recommended that when an employee chose to go to his own physician he should be at liberty so to do.

Comes now the news that Newton County is in a fair way to have a county hospital, to be known as the George Ade Memorial Hospital. In the will left by the famous Hoosier writer it was provided that the trustees of the estate should dispose of the country home of George Ade, known as Hazelden, in any manner they might choose. It is now proposed that this site of eleven acres, near Brook, Indiana, be used as the location of the proposed hospital, that the home building be used for nurses headquarters and a hospital built adjoining. Petitions have been circulated, and there has been negligible objection to the plan; hence, it is generally believed that the project will go through. This not only will prove an incalculable benefit to the local community, but will provide another means of perpetuating the memory of one of Indiana's best-known and most favored authors.

The Indiana State Board of Health, together with Purdue University, plans a cooperative study as to the prevalence of undulant fever in Indiana. For some years past many physicians have believed that the disease is much more common than usually thought, that hundreds of Indiana folk are thus infected. It would materialy help the program if *all* physicians would immediately report such cases as come under their observation. It is our belief that many such cases are not recognized, although more attention is being given the subject than in years past.

It seems that our dental friends now have something to say concerning the socialization of medicine and dentistry. Harvey J. Burkhart, generally regarded as Dean of New York dentistry, recently made a pronouncement on the subject. He stated that the socialization of dentistry would make these members mere "tooth pullers," that effort to preserve teeth would not commonly be made, and that preventive measures would go into discard. This is, of course, true, just as it is in our profession. The regimented dentist will be chiefly interested in the hours required of him and the monthly fee he is to receive.

Via the grapevine comes the information that Tommy Hendricks, now an inmate of 535 North Dearborn Street, Chicago, has a well-developed case of nostalgia. Yes, Tommy is really homesick and is hankering for Indiana and his old cronies among the Hoosier medics. He slips down to our capital city rather frequently, marches right into his old office, looks around a bit, asks a few questions, says "Humph," and walks out. We will not be at all surprised if Tommy, when the annual convention day rolls around, marches right in and tries to take over. Just like the old-time fire horse after he had been retired, when he heard the fire alarm he was up on his toes, wanting action.

It looks as if we may continue to have all the chicken we want, even though the meat supply outlook for some months to come is none too bright. We recently received a "News Bureau" release from the Railway Express Company, stating that just now they are handling, twice weekly, nearly a half million of the "day olds," these being shipped out of Boston to Maryland and Delaware points. There are hatcheries well distributed throughout the country; hence, one can imagine just how large this industry has become. Last fall, while driving back from French Lick, we noted unusually large flocks of fully-grown chickens on almost every farm; a few years ago there would be but a small flock, just large enough to furnish the family with eggs and an occasional "fryer" or "stewer." Better tune up for a rather heavy chicken diet, since this seems to be what is in store for us. Personally, so long as fresh and salt fish are available in the local markets we shall continue to let the chicken "go by."

On occasion we have commented on the increase in printing costs of THE JOURNAL. Well, we again are "upped," this time to a figure quite beyond what we have been paying; in fact, our 1946 magazine will cost us upwards of seven thousand dollars over 1945. As we all are well aware, labor costs are higher than in previous years; then, too, paper stock is hitting for the high spots. THE JOURNAL uses the best paper stock available and, of course, it costs money. However, our advertising for 1946 has also shown a marked upward trend, and with the increase in our space rates we hope it will not be necessary to send out an SOS to the association at the end of the year.

One of the hazards of the current meat shortage is the danger of trichinosis, an infection due to that tiny worm that has a liking for hogs as its host. Pork that has been processed under government supervision—in regulated slaughter houses—is not likely to cause this infection. But these days there is a considerable amount of pork being sold which has not been officially inspected, and it is this product that should have our careful attention. Thoroughly-cooked pork, however, is safe to use, and we should advise our patients to use due care when serving pork in their homes, to see that the dish has been cooked thoroughly—all of which is just another argument in favor of official control of all slaughtered products, as was recently proposed by the Indiana State Board of Health, having every such institution in Indiana under direct supervision of the board.

We have been reading the reports of the hearing on the Wagner-Murray-Dingell Bill, as given in *The Journal of the American Medical Association,* and find them highly interesting. It, of course, is evident that the chairman of the committee, Senator Murray, still is of the belief that his bill is the only solution to the health problem of the nation, but the evidence educed is now on record before the committee and is a public file. The various members of the medical profession who have appeared before the committee have acquitted themselves in a most excellent manner. If we could get the public to read these testimonies they would understand that much of the "pro" material that has been presented to the committee has been carefully "edited" by a small group that is trying to put this thing over. This group, by the way, is composed of non-medical men, men who for at least two decades have been trying to get control of something or other. Holman Taylor, secretary of the Texas State Medical Association, in a recent number of the Texas Journal, reports on the action of that organization, when they sent to the committee their full report in the matter. This is one of the most readable utterances we have seen in connection with the W.M.D. bill.

The medical press has much to say about the new drug "streptomycin," giving an unusual picture in most cases of the successes following its use. In the Missouri official magazine for April, 1946, Abel recites his experiences in the use of streptomycin in several cases of tularemia. In each case he used one million units each twenty-four hours, in divided doses, intramuscularly. There was an almost immediate drop in temperature and the lesion at the site of infection began to heal at once. Two of the cases were of the ulceroglandular type, a third with pulmonary involvement. These case reports indicate that at last we have a definite, successful treatment for a disease that is becoming more common each year, and one that in many instances has baffled every effort of the attending physician.

Away back in the days when we were in medical school, the old Medical College of Indiana, we frequently saw a young Negro physician about town, always busy and always going places, Dr. Sumner A. Furniss. Through the years we have kept in touch with the doings of this man and have noted that he continued as in the days when we first met him—busy, attending to his own affairs and setting an example that might well be emulated by anyone. Dr. Furniss still gets about, attending to his large practice, although he no longer takes "O.B." cases and makes no night calls. He was graduated in 1894 and served as interne for a year in the Indianapolis City Hospital, then opening an office on West New York Avenue, where he was located when we first knew him. The *Indianapolis Times* recently gave him a quarter-page "write up," a well-deserved tribute to a man who has been a credit to his race and a distinct asset to Hoosier Medicine.

It is now only about three months until our next annual session, in Indianapolis, the latter part of October. A preview of the scientific program indicates that as usual it will be of the top-notch order. About the only problem for those in charge is the matter of "housing." It is certain that the attendance this year will be a record breaker; hence, it behooves the "early birds" to arrange for their accommodations right now. The hotel situation, while not as acute as in the past few years, is by no means relieved, so we recommend that members planning to attend make their reservation right now. October 29, 30, and 31 are the dates of the meeting, but it will be well to get to Indianapolis some time on Monday, the 28, thus being assured of an early start on the first day's program. Of course, there will be the annual golf tournament, skeet shoot, and all those things that go to add a little pleasure to the annual gathering. The smoker, so we are advised, will be just that—one of those evenings where one may meet all the old-timers and sit around in "Bull Sessions" to one's own content. Make that reservation right now!

During a milk strike in an Indiana city, babies and the aged and ill were able to procure milk only via the certificate of a physician. In some manner the report got around that physicians were charging a fee for the certificates, causing no little commotion. However, the local medical group scotched that report before it had gained much headway, and all was well again. Never in our long experience as a practitioner of Hoosier Medicine have we known an instance in which a single professional man made a charge for such services.

According to the annual hospital number of *The Journal of the American Medical Association*, the American people are "taking to" hospitalization in increasing numbers every year. More than sixteen million people were admitted to first-class hospitals in the country in 1945, and almost two million babies were born in these institutions. Well do we recall, "way back when," when the mere suggestion that a patient be sent to a hospital evoked quite a discussion in the family affected; a lot of folk held the old idea that the hospital was a place in which to die, comfortably. Today the mere suggestion of hospitalization most always meets with an immediate acquiescence, the only problem being to find a vacant hospital bed. At long last America has become hospital-conscious.

In an open letter "to the People of Randolph County," Dr. A. Henderson, spokesman for his local medical society, speaks frankly about matters concerning the local county hospital. He avers that for years past the institution has not been adequate, and that pleas by the local profession for betterment of conditions have fallen on deaf ears, stating that the head of the local board has done nothing about it, his reason being that he wanted to avoid an increase in taxes.

According to the letter, this condition has existed for a long time, but only recently did the final "blow up" come, when it was announced that the hospital would be closed for two weeks, beginning June sixteenth. The local medical staff had countered with the proposal that a few beds be maintained during this period for emergency cases only, but even this was denied them. A paragraph in the letter says, "We doctors have never found it expedient to strike, but when our hospital goes on strike we need to take stock." Further comment is to the effect that people continue to get sick, and to have accidents, and babies continue to be born even though the hospital is closed.

To our mind this is but another example of lay control of our county hospitals; we had another instance of this not long ago, when the Sullivan County Hospital Board made some drastic moves that resulted in the entire staff leaving the hospital for a short time, until intolerable conditions had been remedied. After all, the staff members usually know more about running a hospital than a group of untrained laymen!

President's Page

A review of the happenings in our state organization during the past six months is in order. Many momentous decisions have been made that revolutionize our previous way of thinking.

First of all, after many months of discussion pro and con, an insurance plan has been formulated by the members of this association, which we hope will neutralize some of the propaganda that has emanated from men high up in Government, who are recommending that a National Compulsory Health Insurance plan be adopted. How far our activities will go, no one can tell at the present moment, but we earnestly hope that it goes all the way. Let us all keep a high point of optimism and not reduce for one moment our vigilance, and make earnest endeavor to beat all such vicious proposed legislation to the draw in the future.

Another endeavor that I believe is a great step forward and that is the organization of the General Practitioners into a group to which I think every G. P. will be proud to be a member, because of prestige, and the chance to better our understanding of the advances in the science of medicine. Everything is in order for the final consummation of this organization. Every member who belongs will be known as a Diplomate of the General Practice. Each member will receive a special certificate indicating their membership, which should be displayed in his or her place of business. This committee deserves special mention for the fine work that it has accomplished.

Some may ask, why join? In answering this question in a brief way, I will say that instructional courses are planned for members only. That to my opinion will well be worth the price paid for membership.

The time will soon be here for the regular State Convention. I assure you that if hard work by the different committees is any indication we will have one of the best conventions that has ever been held. The committees on arrangement and scientific programs are very hard at work, and if they are successful in bringing to life all their high ideals, I am sure that every one attending will be highly repaid from the scientific information received. Also in a lighter vein the entertainment will be the best ever. It is reassuring to me that we have such fine men as members of these different committees, and that their willingness to sacrifice so much of their valuable time to put across a general program that will be second to none. We assure them it is appreciated.

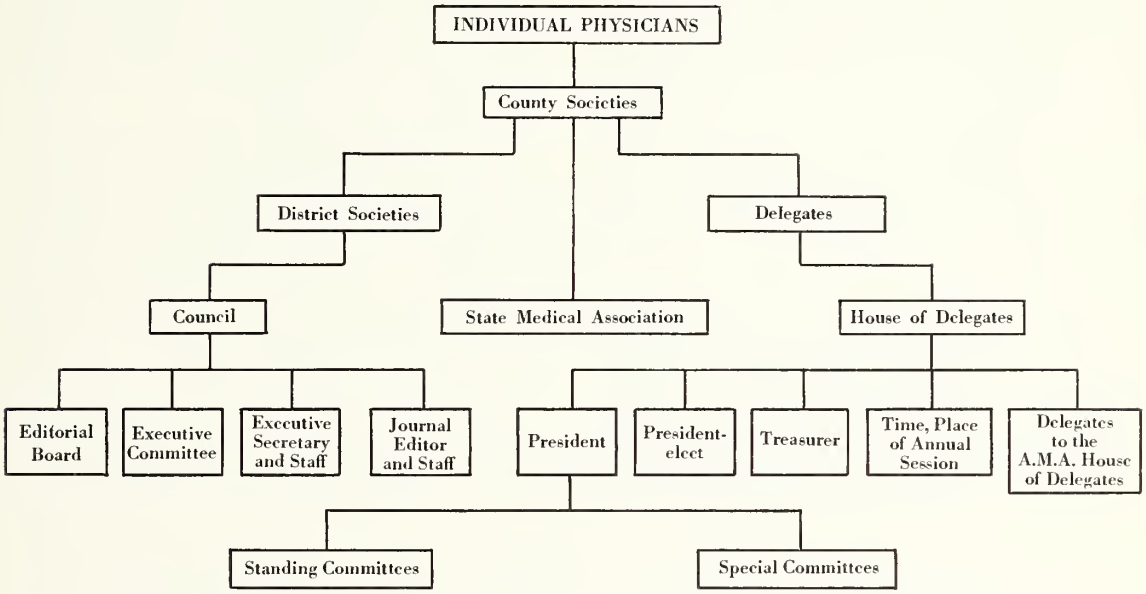
American Medicine now being the target for every one to take a pot shot at, let us just for the sake of argument take some shots at ourselves. Where are we short? Have we been unfair to the people of this Nation? In answer to the first question, the medical profession is the only profession that works against itself from the financial standpoint. If we are so neglectful of the public as we are pictured to be, then why do we endeavor to prevent the spread of diseases? Why do we go out of our way and indorse and co-operate in all the programs put forth by the National Public Health Organization? We would get more pay if diseases were allowed to develop unchecked. If we are as selfish and monopolistic as pictured we must be a drag on society. If this is all our efforts are appreciated, let's close all the medical schools in the country and do away with hospitals, now! What would be the results? Every one knows the answer. I do not believe any sane person in these United States wants this to happen, and with this picture before you it would be a very grave calamity, then unfairness could be laid at our feet and we should be pointed at with scorn. On the other hand the profession has been very fair and will still be more fair if the Government and certain groups will only let us, provided also that we are able to deal with health-educated citizenry, and by that is meant that there should be a revamping of our school system. That should include teaching the pupils of all grades from the primary to the fourth year of high school the fundamentals of the laws that govern good health. Where could these things be taught more thoroughly? If the boys and girls have the basic knowledge, how much easier it would be for physicians to have their directions in the line of preventive medicine carried out for the good of all.

J. E. Farrell

INDIANA STATE MEDICAL ASSOCIATION

[Editor's Note: This chart and the explanation which follows it are published by direction of the House of Delegates, in accordance with a recommendation of the Committee for the Study of Lay Activity in Medical Practice.]

A Simplified Organization Chart
of the
INDIANA STATE MEDICAL ASSOCIATION



EXPLANATION OF DUTIES

Individual Physicians. Only by becoming a member of the local county medical society can a physician attain membership in the Indiana State Medical Association. Each local society is judge of its own membership.

County Societies. The 83 county medical societies in the state embrace all of Indiana's 92 counties. Officers are elected annually by the members.

District Societies. There are 13 district societies. Each county society is a part of one of the districts. Officers are elected annually, and each member of a county society at the district meeting is privileged to vote. Every third year a councilor is elected to represent the district on the council of the Indiana State Medical Association.

Delegates. Each county is entitled to at least one delegate to the House of Delegates, and for additional delegates for each 50 members, or major fraction thereof, after the first 50 members. The length of terms of delegates is determined by the local societies.

Council. The council is the executive body of the association. It has four stated meetings a year, and may meet in special session at the call of the chairman. It acts as the Board of Censors, and among its other duties is control of finances and supervision of all publications. It has full authority and power of the House of Delegates when the House of Delegates is not in session. Each councilor is organizer, peacemaker, and censor for his district.

House of Delegates. The House of Delegates is the legislative and business body of the association. It meets twice during the annual session, and in special session at the call of the president, who is the presiding officer. It elects the association officers annually, and elects the Indiana delegates to the House of Delegates of the American Medical Association. Besides the delegates, the councilors and ex-presidents of the association are members of the House of Delegates with power to vote.

Editorial Board. The council elects members of the Editorial Board. The board supervises the editorial policy of THE JOURNAL for the council.

Executive Committee. Two members of the executive committee are elected by the council, and they, together with the president, president-elect, and chairman of the council make up this committee. It composes the Committee on Medical Defense. It performs the functions of the council when the council is not in session.

Executive Secretary. He is engaged by the council on a year-to-year basis. His duty is to keep all association records, minutes of meetings of the House of Delegates, council and executive committee, serve as secretary of the committees, act as managing editor of THE JOURNAL, arrange for the annual session, do public relations, assist councilors in organization work, etc. The executive secretary is manager of the association headquarters.

Journal Editor and Assistants. The council appoints the editor of THE JOURNAL and his assistants.

President. He is elected by the House of Delegates. The president presides over the House of Delegates and is the real head of the medical profession of the state.

President-elect. He is elected by the House of Delegates and ascends to the presidency at the end of his one-year term. He is assistant to the president, and succeeds him in event of a vacancy in that office.

Treasurer. The House of Delegates elects him. He is in charge of the association's funds.

Time and Place of Annual Session. The time and place for the annual session are decided by the House of Delegates.

A.M.A. Delegates. The delegates from the Indiana State Medical Association to the House of Delegates of the A.M.A. are elected by the House of Delegates.

Standing Committees. All these committees with the exception of the Executive Committee are appointed by the president. The standing committees are:

The Executive Committee (composed of the president, president-elect, chairman of the council and two members elected by the council).

A Committee on Arrangements.

A Committee on Scientific Work.

A Committee on Public Policy and Legislation.

A Committee on Publicity.

A Committee on Industrial and Civic Relationship.

A Committee on Medical Education and Hospitals.

A Committee on Budget.

A Committee on Public Relations.

Special Committees. The committees are appointed by the president in accordance with the need for them.

MEDICAL HISTORY OF WORLD WAR II WILL BE WRITTEN IN THREE PARTS

The first meeting of the Advisory Editorial Board on the Medical History of World War II was held in the Office of The Surgeon General on May 9, 1946. The meeting was opened by Major General Norman T. Kirk, The Surgeon General, who assured the Board of his interest in the medical history. He expressed the hope that with the assistance of the Board and the contributors "the job of writing the history would be as well done as was the job done by the men and women who made medical history during the war."

Colonel J. H. McNinch, M.C., Director of the Historical Division of the Office of The Surgeon General, offered for the Board's consideration a revised plan for the publication of the history. According to Colonel McNinch, the wealth of information accumulated on the Medical Department's experience in World War II should be organized and published in accordance with the interests of specialized audiences. Consequently, the history will be divided into three parts.

Part I of the history will be devoted to the operation and administration of the Medical Department. Eight volumes are planned on this phase of the history which will cover such topics as supply and fiscal activities, evacuation, personnel procedures, overseas medical service, hospital construction, and the like. These volumes will tell the story of how the medical service functioned in war. They are to be written by competent historians and it is estimated that at least four years will be required to prepare this part of the history. These volumes will be incorporated in the War Department History.

Part II, which will consist of a number of volumes to be determined later, will be designed for professional readers and will cover the Medical Department's clinical and technical experience in medicine, surgery, psychiatry, preventive medicine, aviation medicine, physical medicine, dentistry, and veterinary medicine. Early publication of the clinical and technical volumes is planned.

Part III of the history will consist of a series of medico-military monographs dealing with various specialized subjects of interest primarily to officers of the Regular Army.

PROGRESS OF INDIANA BOARD OF GENERAL PRACTICE OF MEDICINE

A bulletin regarding the organization and plans of the Indiana Board of General Practice of Medicine is now in the hands of the printer and soon will be available at the headquarters of the Indiana State Medical Association.

It gives a statement of the origin of the board, of its purposes, and of the parts of the By-Laws relating to the manner in which membership will be obtained. Plans are being made for the first examination of applicants to be held either during or prior to the time of the next state convention. In order that there may be time enough to make adequate plans for the examination of those who desire to have their applications acted upon by the time of the next state convention, the applications should be received by August 15, 1946.

This is necessary because of the fact that the Committee on Qualifications will have to have some time to perform their functions as fixed in the By-Laws, to determine whether the applicant is eligible to take the examination. In order to be qualified for membership and permitted to take the examination, the Committee on Qualifications must be satisfied that the applicant meets the following requirements:

1. Membership in a local county medical society and citizenship of the United States.

2. High moral and ethical standing in the profession.

3. Graduation from a medical school recognized by the Council on Medical Education and Hospitals of the American Medical Association.

4. Completion of an approved internship, preferably of the general rotating type, in a hospital approved by the same Council of the American Medical Association.

5. Continuance of post-graduate education.

6. A minimum of five years of general practice after completion of an approved internship.

In special instances the board may accept for examination outstanding candidates who were in practice prior to January 1, 1930, but whose formal training does not comply with the full preliminary requirements.

It is obvious that the Committee on Qualifications will need some time to check the candidates as to all the above requirements.

It is the hope of the incorporators and directors of this board that it may give great stimulus to scientific interest in the general practice of medicine. While the founders' membership list has not been closed, the incorporators have found that this board has created considerable discussion among doctors in general practice. They feel much encouraged by the progress already made and believe that when the general practitioners are better acquainted with the whole enterprise there will be a great many applicants for membership on the board.

In recognition of the attainment of membership on the board and the passing of all the examinations for that purpose, the board will award to the applicant a Certificate of Membership, conferring the honor of "Diplomate of the Indiana Board of General Practice of Medicine." The document will be suitable for framing and hanging on the wall in an office.

It is the intention of the board to make it possible for physicians in general practice to be able to obtain membership on the Board if they desire and will work for it, but membership will not be conferred merely as a matter of routine. It will represent genuine achievement and interest in the general practice of medicine, and the Board believes that it will not be long until general practitioners of medicine will prize highly membership on the Board, just as members of boards of specialties now do.

GENERAL KIRK PRAISES DDT IN RADIO ADDRESS

DDT was a large factor in our winning the Pacific War, Major General Norman T. Kirk, the Surgeon General, stated in an address over the ABC network on April 28.

"In the early stages of the Pacific war, malaria was taking out of action ten times as many soldiers as were Japanese bullets," General Kirk declared. "The success of our arms in the Pacific was in jeopardy until we got malaria under control. DDT helped us win that battle."

General Kirk was appearing on a program originating in New York City in which the dramatic story of preventive medicine was being told. In describing the part played by the Medical Department, he stated that fear of tetanus, yellow fever and typhus had become a thing of the past.

"There have been no deaths from those diseases among American soldiers who were innoculated against them," General Kirk said.

MAKE YOUR HOTEL RESERVATION

for the

Annual Session of the Indiana State Medical Association

Indianapolis, Indiana October 29, 30, and 31

The largest attendance in history is anticipated for the annual session of the state association, in Indianapolis, October 29, 30, and 31. An excellent program of scientific meetings, sports events, and entertainment is being arranged.

All the sessions will be held at the Murat Temple.

Following is a list of Indianapolis hotels and their rates:

Antlers Hotel, 750 N. Meridian St.: 200 Sleeping Rooms. With Bath—Single Rooms, $3.00-$3.50; Double Rooms, $5.50-$6.00; Twin-Bedded Rooms, $5.50-$6.00.

Barton Hotel, 505 N. Delaware St.: 150 Sleeping Rooms. Without Bath—Single Rooms, $1.25 - $1.50; Double Rooms, $2.25 - $2.50. With Bath—Single Rooms, $1.50 - $2.00; Double Rooms, $2.50 - $4.00.

Claypool Hotel, Washington and Illinois Sts.: 500 Sleeping Rooms. With Bath—Single Rooms, $3.30 - $6.00; Double Rooms, $5.00 - $6.50; Twin - Bedded Rooms, $6.00-$8.80; Parlor Suites, Single, $11.00; Double, $13.30.

English Hotel, Monument Circle: 200 Sleeping Rooms. Without Bath—Single Rooms, $1.75 - $2.50; Double Rooms, $2.50 - $4.00. With Bath—Single Rooms, $2.50-$5.00; Double Rooms, $3.50-$8.00; Twin-Bedded Rooms, $5.50-$8.00.

Harrison Hotel, 51 N. Capitol Ave: 125 Sleeping Rooms. With Bath—Single Rooms, $2.75-$4.50; Double Rooms, $4.00-$6.00; Twin-Bedded Rooms, $6.00; Suites (Two Rooms), $8.00-$9.50.

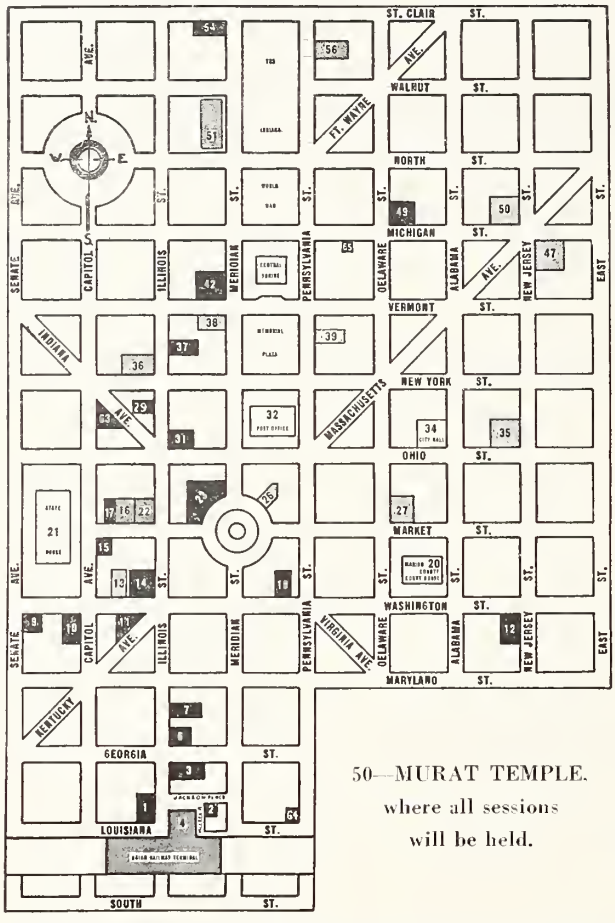
Lincoln Hotel, 117 W. Washington St.: 400 Sleeping Rooms. With Bath — Single Rooms, $3.50 - $6.00; Double Rooms, $5.00 - $8.00; Twin - Bedded Rooms, $6.00-$8.00; Suites, Single, $10.50 - $13.50; Double, $12.50 - $15.50.

Linden Hotel, 311 N. Illinois St.: 300 Sleeping Rooms. Without Bath—Single Rooms, $1.25 - $1.50; Double Rooms, $2.50 - $3.00. With Bath — Single Rooms, $2.50-$3.00; Double Rooms, $3.50-$4.50.

Marott Apartment Hotel, 2625 N. Meridian St. (Permanent and Transient): 1,004 Sleeping Rooms. With Bath — Single Rooms, $3.00 and up; Double Rooms, $5.00 and up; Twin - Bedded Rooms, $6.00 and up; Parlor Suites, $9.00-$16.50.

Pennsylvania Hotel, 947 N. Pennsylvania St.: 60 Sleeping Rooms.

DOWNTOWN DISTRICT OF INDIANAPOLIS



Hotels—54 Antlers, 2 Barnes, 49 Barton, 31 Brevort, 14 Claypool, 23 English, 64 Gilbert, 15 Harrison, 12 Kirkwood, 11 Lincoln, 37 Linden, 10 Lorraine, 65 Michigan, 63 Plaza, 3 Severin, 1 Spencer, 42 Spink Arms, 17 Stratford, 6 Stubbins, 7 Warren, 18 Washington, 9 Williams, and 29 York. (Graylynn, Marott, Pennsylvania, Riley, and Sheffield Inn not shown.)

Transportation Terminals—4 Union Station, 16 Bus Terminal, and 22 Traction Station.

Miscellaneous—56 Armory, 47 Athenaeum, 26 Columbia Club, 13 Indiana Ballroom, 38 Indianapolis Athletic Club, 50 Murat Temple, 51 Scottish Rite, 27 Tomlinson, 36 Y.M.C.A., and 39 Y.W.C.A.

We Urge You To Write *Immediately* For Your Hotel Room!

With Bath—Single Rooms, $2.25; Double Rooms, $3.25; Twin-Bedded Rooms, $3.75.

Riley Hotel, 155 W. 16th St.: 100 Sleeping Rooms. Without Bath—Single Rooms (Running Water), $1.50-$1.75; Double Rooms (Running Water), $2.75-$3.00. With Bath—Single Rooms, $2.25-$2.75; Double Rooms, $3.50-$5.00; Twin-Bedded Rooms, $5.00.

Severin Hotel, 201 S. Illinois St.: 400 Sleeping Rooms. With Bath—Single Rooms, $3.00-$5.00; Double Rooms, $4.50-$6.00; Twin-Bedded Rooms, $5.50-$7.00.

Sheffield Inn, 958 N. Pennsylvania St.: 90 Sleeping Rooms. With Bath—Single Rooms, $2.50-$3.00; Twin-Bedded Rooms, $3.50-$4.50.

Spencer Hotel, 248 S. Illinois St.: 200 Sleeping Rooms. Without Bath—Single Rooms, $1.50; Double Rooms, $2.50. With Bath—Single Rooms, $2.25-$2.50; Double Rooms, $3.50-$4.00; Twin-Bedded Rooms, $3.50; Suites, Two Persons, $5.00; Four Persons, $8.00.

Spink Arms Hotel, 410 N. Meridian St.: 400 Sleeping Rooms. With Bath—Single Rooms, $2.50-$5.00; Double Rooms, $4.00-$6.00.

Warren Hotel, 123 S. Illinois St.: 250 Sleeping Rooms. With Bath—Single Rooms, $2.50-$4.00; Double Rooms, $3.50-$6.00; Twin-Bedded Rooms, $5.25-$6.00.

Washington Hotel, 34 E. Washington St.: 300 Sleeping Rooms. With Bath—Single Rooms, $2.50-$4.00; Double Rooms, $4.00-$6.00; Twin-Bedded Rooms, $5.00-$7.00; Suites, Single, $6.00; Double, $8.00-$9.00.

Columbia Club, Monument Circle: 125 Sleeping Rooms. With Bath—Single Rooms, $3.50-$5.00; Twin-Bedded Rooms, $5.50-$7.50; Suites, Single, $8.00; Double, $12.00.

Indianapolis Athletic Club, 350 N. Meridian St.: 150 Sleeping Rooms. With Bath—Single Rooms, $3.50-$5.00; Twin-Bedded Rooms, $7.00-$8.00; Suites, $10.00-$14.00.

Note: Arrangements for these private club facilities can be made only through the members of the club.

THREE YEARS OF JAPANESE IMPRISONMENT HAS LITTLE EFFECT ON MINDS OF AMERICAN SOLDIERS

Three years in Japanese prison camps, most of the time on starvation rations and subjected to frequent beatings, had surprisingly little effect on the minds of more than four thousand American soldiers who survived the ordeal.

Wherever these men landed in the United States after liberation they were met by teams of medical specialists assigned from the Office of the Surgeon General. A report on the neuropsychiatric findings has just been made by Lieutenant Colonel Norman Q. Brill, who was in charge of this phase of the examinations.

Considerable importance was attached to early medical contact with the released soldiers because, says Dr. Brill, "never before in this country's history had such a large group been exposed to starvation, torture, and humiliation." The psychiatrists were interested in the factors that were responsible for the survival of these men when so many of their comrades, in about the same physical condition when captured, had succumbed. The nearest they came to finding a common factor, however, was what is described in the report as a "tremendous will to live." Otherwise the soldiers differed in about every possible way.

"All of them," says Colonel Brill's report, "lived only for the day. Indeed when one of them would fail to concentrate on or begin to hoard food, or gave way to morbid thoughts concerning the seemingly hopeless situation, he was earmarked by his companions as quite likely to die shortly. A prisoner who would hoard his rice allowance for several meals in order to enjoy the sensation of one large meal was referred to as 'rice happy.' This was generally an indication of the beginning of deterioration and early demise.

"When those of lesser spiritual strength became ill they were likely to give up, quit eating entirely, and frequently would die within a few days. One fails to find a scientific reason or an adequate term to explain survival. It seemed to some of the examiners that 'courage' was the best word. It seemed that the only common factor among the survivors was that they had courage. They never stopped in their struggle for survival. They ate anything available, including cats, dogs, silk worms, and other things repulsive to normal human beings. When struck with dysentery and malaria they would nevertheless attempt to carry on. This strength and courage had no connection with social background or education."

The men themselves, Colonel Brill said, expressed no concern about their ability to readjust to life in the United States. Regardless of the future, they felt that they would meet any situation likely to arise after living through the prison camp years.

Military News

After approximately three years of service in the Army Medical Corps, Captain Charles B. Emery, of Bedford, has resumed his practice there.

After a tour of duty in the Pacific, Captain William P. Marshall, of Indianapolis, is back in the United States, and is now located at the Percy Jones General Hospital at Battle Creek, Michigan.

Lieutenant-Colonel J. G. Bledsoe, of New Castle, opened offices at 319 South Fourteenth Street there, after extensive remodeling of the building. Doctor Bledsoe is a veteran of the Army Medical Corps.

Formerly of Indianapolis, Dr. Lawson F. Smith has taken over a general practice in La Veta, Colorado, following his recent release from the Army. His three-year service included several months in Tokyo.

A veteran of forty-two months' service with the Army, Captain Howard W. Beaver, of Indianapolis, has announced the opening of an office for general practice in Indianapolis. Doctor Beaver served with the 37th General Hospital in Africa and Italy.

After a well-deserved rest, Captain Alvin T. Stone, of Indianapolis, will resume practice there. Doctor Stone was discharged on May fifteenth, after thirty months' service in the Army. For nine months he was in Batangas Province, P. I., where he served as battalion surgeon for the 69th Ordnance Battalion.

After three and one-half years in the United States Public Health Service, Dr. Norval C. Folkening, of Indianapolis, is now back home, and has opened an office in the Fountain Square Theater Building, in Indianapolis. He was stationed at United States Marine Hospital in New York City and Buffalo, New York, and was assigned to temporary duty in the British West Indies.

Recently discharged from the service, after serving four and one-half years with the Army Medical Corps, Dr. Basil M. Merrell has assumed the practice of the late Dr. T. J. Collings, of Rockville. Doctor Merrell served overseas with the Persian Gulf Command, and in the China-Burma-India Theatre for twenty-eight months, and for several months prior to his discharge was post surgeon in the Army War College, in Washington, D.C.

Recently discharged from the Army Medical Corps, Lieutenant Bruce A. Work, of Clinton, has resumed his practice there.

Major Charles A. Reid, recently out of the Army, is building an office at 2445 Shelby Street, in Indianapolis. Doctor Reid served as a transport surgeon.

Having finished his surgeon's flight training at Randolph Field, Lieutenant John R. Moriarity, of Indianapolis, is now with the 4105th AAF at Davis-Mouthan Field, in Tucson, Arizona.

Following his discharge from the Army, with the rank of major, Dr. Jack C. Blackstone, of Indianapolis, has accepted a residency at the Nashville General Hospital, in Nashville, Tennessee, where he expects to be for the next two years.

Major William M. Kendrick, of Indianapolis, has opened his office at 4602 Norwaldo, in Indianapolis, after approximately four years in the Army. Doctor Kendrick spent nine months on Guam, where he served as assistant chief of the medical service.

Lieutenant-Colonel Charles F. Seaman returned to practice in Indianapolis in June, following his discharge from the service in April. Doctor Seaman spent four years in the Army, one year of which was served in France and Germany with the 66th Field Hospital.

Major Buckman Gardner, of Indianapolis, who served in Africa as flight surgeon of the 15th Photo Mapping Squadron, Third Photographic Group, has opened an office at 134 East Twenty-second Street, in Indianapolis. Returning to the United States in 1943, Doctor Gardner was stationed at Fort Lewis, Washington, and was placed on inactive status at Camp Sibert, Alabama, where he was post surgeon.

After many months' service overseas with the Army Medical Corps, Major Katherine Jackson, in general practice for several years at Patriot, is spending her terminal leave in Fort Wayne. Her first assignment upon entering military service was at the Walter Reed Hospital, in Washington, D.C., as an anesthetist. From there Major Jackson went overseas and was on duty in France, Belgium, and Germany. She attended several sessions of the War Crimes Trials in Nuernberg while stationed in Germany.

Captain James E. Engeler has been discharged from the Army and is living at 404 N. Lebanon Street, in Lebanon, but he hopes to locate in Indianapolis.

Dr. Lyman H. Ellis, who has just returned from forty-five months' service with the Army Medical Corps, has opened an office in Lizton. Doctor Ellis is a native of Lizton, but practiced in Lebanon before entering the Army.

Dr. David A. Morrison has resumed the practice of general surgery at Kokomo, after serving three and one-half years in the Navy. A commander at the time of his discharge, he saw duty in the Pacific Theatre.

Captain Joseph L. Larmore, who was released recently from the Army Medical Corps, has established an office in Anderson. Doctor Larmore served for the past year as chief of the eye section of the 19th General Hospital in India and Burma.

In service for three and one-half years, Major Joseph E. Lang, of South Bend, has been discharged, and has resumed his practice. Doctor Lang served at Fort Knox, Kentucky; Billings General Hospital, in Indianapolis; and at Camp Gordon, Georgia.

After forty-five months in military service, Lieutenant Colonel Ralph J. McQuiston, of Indianapolis, has returned to practice at 608 Guaranty Building. Since his release in January, Doctor McQuiston has been in New York, working with Dr. Julius Lempert and Dr. Samuel Fomon.

Discharged from the Army Medical Corps with the rank of major, on February 28, 1946, Dr. George W. Seward has resumed his practice of medicine at his old location, in North Manchester. He entered the service on July 25, 1942, and was in the Air Corps, first at Wright Field, Dayton, Ohio; and later at Harrisburg, Pennsylvania; and Everett, Washington.

Lieutenant Colonel Daniel D. Stiver, of South Bend, has resumed the practice of general surgery there, after approximately four years' service in the Army. Entering the Army as a captain in May, 1942, his tour of duty took him to Camp Forrest, Tennessee, and Camp Bowie, Texas, before he was assigned to a field hospital at Bandar Shahpur, in southern Persia. He served there for eighteen months before being assigned to the Gardiner General Army Hospital, in Chicago, in June, 1944.

Captain John H. Alward, of South Bend, is now stationed at the Station Hospital, Smoky Hill Army Air Field, Salina, Kansas. He was formerly at the Sioux Falls Army Air Base, Sioux Falls, South Dakota.

Lieutenant Colonel Frank G. Sink, who served overseas with the 123rd General Hospital for fourteen months, and five years on active duty with the Medical Corps, has now resumed his practice in Remington.

Commander Nelson B. Combs, of Mulberry, recently returned from active duty with the Navy, and will resume his practice there after completing a refresher course in eye, ear, nose and throat work.

Following five years in military service, two and one-half years of which were spent overseas, in the European Theatre, Lieutenant Colonel Kenneth G. Hill has opened an office in Middletown. Doctor Hill has been associated with St. Elizabeth's Hospital, in Lafayette, for the past four months.

Having been in the service for forty-two months, Captain Robert W. Donnelly, of Sullivan, has returned to private practice, in Sullivan. Doctor Donnelly was attached to the Finney General Hospital, at Thomasville, Georgia, and saw extensive service overseas with the Third Division, in the European Theatre of War.

The Bronze Star Medal has been awarded Captain Harold E. List, of Marion, for meritorious service while assigned as senior medical officer aboard the *U.S.S. Belleau Wood.* The medal was awarded Captain List for outstanding service on October 30, 1944, when the ship was hit by a Jap suicide plane off Samar, P. I., and serveral hundred of the personnel were injured. Captain List entered the service in 1941.

Discharged as a major last January, Dr. J. Lawrence Sims has resumed his practice in Indianapolis, after serving for four years in the Army Air Forces Medical Corps. He entered the service July 2, 1942, and was stationed at Selfridge Field, Michigan, for twenty-seven months, then was transferred to the Myrtle Beach Army Air Field, South Carolina, for fifteen months, as chief of E.E.N.T. Service. He was stationed last at the Kennedy General Hospital, in Memphis, Tennessee, until his separation from service. He was assistant chief of service there. Although he is glad to be back, Doctor Sims says he was lucky in having a nice service all the way through.

Captain Francis G. Sheehan, of Indianapolis, has taken over the practice of Dr. Walter F. Kelly, who is retiring. Doctor Sheehan was a paratroop surgeon in the Army, and many readers will recall references to him in the late Ernie Pyle book, "Brave Men."

We apologize to Dr. Hubert T. Goodman, of Terre Haute, for an error which occurred in our May issue of THE JOURNAL, in which his rank was reported as that of major, whereas he was promoted to lieutenant colonel while on active duty in China in June, 1945.

With the Public Health Service during his four-year Army service, Major Wayne L. Ritter, of Indianapolis, was stationed in Connecticut, Mississippi, and Kentucky. He is now back in practice, specializing in internal medicine, in the Hume Mansur Building, at Indianapolis.

Lieutenant Colonel Loren Ake, of Cambridge City, has returned to private practice there after five years and two months of military service. He served overseas in the Southwest Pacific area for twenty-two months, participating in the New Guinea, Leyte, and Luzon campaigns. While overseas Doctor Ake was chief of the surgical service of the 125th Station Hospital, and later was on the staff of the 49th General Hospital.

After twenty-one months service in the Pacific Theatre, Captain Samuel S. Caplin, of Indianapolis, has resumed the general practice of medicine there. He was with the 49th General Hospital, the 35th General Hospital, 117th Station Hospital, and 54th Evacuation Hospital, and is entitled to wear battle stars for the New Guinea, South Philippine, and the Luzon campaigns; and to wear the Philippine liberation, American defense, Asiatic-Pacific, and Victory ribbons.

Lieutenant Howard H. Marks has located in Huntington, after forty-three months' service with the Air Force. He entered the service in July, 1942, which terminated February 26, 1946. Acting as squadron surgeon of the 12th Photo Reconnaissance Squadron, 3rd Photo Group, Doctor Marks went overseas in September, 1942, and after six weeks in England he was transferred to North Africa at the onset of that campaign. At the close of the North African campaign he returned to the United States for training as a flight surgeon, and when his training was completed he was assigned to the First Troop Carrier Command for the remainder of his Army service, which included Baer Field, Fort Wayne; Bergstrom Field, Texas; and Stout Field, Indianapolis.

Commander Richard L. Hane, of Fort Wayne, has been released from the Navy, following service in this country and overseas. Doctor Hane entered the Navy on July 3, 1942, and was stationed at the Great Lakes Naval Hospital, and then served as senior medical officer of an advance hospital base in the Solomons. He was later attached to United States Fleet Hospital 104, at Auckland, New Zealand, and Hospital 107, at Noumea, New Caledonia. Returning to this country on November 26, 1944, Doctor Hane has been serving at the Naval Hospital in Astoria, Oregon, since that time.

When Captain Robert M. Hansell, of Indianapolis, sailed from Marseilles, France, on August 11, 1945, he was bound for the Philippines, but "like ships that sailed for sunny isles, he never came to shore," for as his ship was on the ocean on its way to the Panama Canal, word was received that the war was over. Nothing happened, and they kept going for two days, but Captain Hansell explained that that had been all right so long as the war was on, but now no gale that blew dismayed the crew more than the thought of going to the Philippines. On the second day, however, their nostalgia was appeased, for they received a radiogram to land at Newport News—what a message for the 775 officers, of whom 240 were medical officers.

Captain Hansell entered the Medical Corps on November 4, 1943, and after serving at Carlisle Barracks, Billings General Hospital, Nichols General Hospital, and the Fort Knox Station Hospital he was sent to Camp Grant, where he joined the 163rd General Hospital which sailed for England on August 30, 1944, and located near Cambridge. The unit functioned as a hospital until June 10, 1945, and during this time also served as a station hospital for the air forces.

While in England Captain Hansell finally managed to find a location center in a hideaway in London where they had a file on everyone in the ETO, but even so he never saw anyone he knew except William H. Norman, Bennett Harvey, and Joseph L. West, all of Indianapolis. On one occasion he was able to spend a week end in Scotland, a priest, a dentist, and a laboratory man going with him. The four having slept late the first day of their leave had missed breakfast, and in their rush to get something to eat two of them dodged into a tea shop in the station, got in line, and when the man who was pouring tea and serving rolls looked at them, they asked for sixteen sandwiches, whereupon the overwhelmed tea-pourer said, "zzz-zixteen?" They got the sixteen sandwiches!

Since his return to the United States Captain Hansell has served at Billings General Hospital and the station hospital at Benjamin Harrison, and was discharged on May twenty-eighth. He plans to resume his private practice in Indianapolis at the end of his terminal leave.

COLONEL PFAFF SERVED WITH TROOP CARRIER COMMAND

Colonel Dudley A. Pfaff, of Indianapolis, deserves much credit for the service he rendered in World War II. Called to active duty on January 17, 1941, with the 113th Observation Squadron, Indiana National Guard, he later became the assistant surgeon of the 1st Troop Carrier Command, and ultimately in October, 1945, became the command surgeon. Later he served as command surgeon for its successor, the 9th Troop Carrier Command.

At Key Field, Mississippi, he was sent on Louisiana Training Maneuvers that summer, and following "Pearl Harbor" was hurried to Tampa, Florida, on Submarine Patrol and later to New Orleans.

He was transferred to the 1st Troop Carrier Command, at Stout Field, Indianapolis, in July, 1942. This Command was really in its infancy, having been organized in Washington and transferred here in May, 1942. His first job was that of getting doctors for the Troop Carrier Group and their hospitals; then the next job was that of getting supplies. The supply service caused headaches aplenty for Colonel Pfaff, who mentioned making one trip to St. Louis to the Medical Supply Depot, picking up equipment and flying it to Ogden, Utah, to give it to a squadron flying to Alaska. After that came the maneuvers in Carolina with the Airborne and Glider Infantry, preparatory to the invasions of Africa, Sicily, and Normandy.

The Troop Carrier Command was a combat organization. It flew paratroopers and gliders into battle, evacuated the wounded, kept aerial supply lines open in the midst of battle, and often penetrated to distances behind the enemy lines. Its motto was, "He conquers who gets there first."

The Troop Carrier Command can look back with considerable pride on its record. The Troop Carriers dropped the first American paratroopers in North Africa; they spearheaded the invasion of Sicily, Normandy, Saipan, Iwo Shima and the Phillipines, and evacuated thousands of wounded in every theatre of operation. The Troop Carrier Command was commended by General Dwight D. Eisenhower for its "remarkable record, great fortitude, superior organization and training"; and General MacArthur cried out, "Beautiful! Wonderful!" as he viewed one of its landing scenes.

There were only two full Carrier Commands, the 1st and the 9th. The 1st never went overseas, for it was a training unit. Several wings and many groups were trained and sent overseas. "Our job," said Colonel Pfaff, "was to see that each one of the units had a medical organization, to train them not only to run a dispensary, but in air evacuation as well." The Command Surgeon's Office also supervised the training of the nurses at the School of Air Evacuation, at Bowman Field, Louisville. Flight surgeons, nurses and enlisted personnel were given special courses. The rigid training program included the principles of aviation, medicine, and the effects of flight on patients.

Several other things had to be developed, such as the snatch glider pick-up, which was used in Europe in picking up the wounded across the Rhine and flying them back to the hospitals in France.

The Carrier Command also assisted the Air Cargo Re-supply Squadron in training its force in packing and dropping medical supplies, and x-ray outfits, et cetera—delicate equipment was dropped by parachute, and durable items with a free throw. It also assisted in the training of personnel for aerial spraying of DDT for pest control, an achievement which will be continued in peacetime.

The Troop Carrier Command has, indeed, proved itself by carrying out the mission for which it was created—To Get There First!

After serving in the Army for five years and three months, Colonel Pfaff is "Glad to be back," a comment which is quite understandable. He has now resumed his practice of general surgery, with his office located in the Hume Mansur Building, at Indianapolis.

Contrast transport by air as compared with hauling over ground in difficult terrain.



Ambulance bogged down in Louisiana Maneuvers.



Air Evacuation by C-47 with a capacity of twenty-four litter patients.

Deaths

Clarence A. Toles, M.D., of Indianapolis, died on May sixteenth at the age of sixty-five. Doctor Toles graduated from the Indiana University School of Medicine, in 1909, and had practiced in Indianapolis for more than thirty years.

James L. Beatty, M.D., of New Market, died on May thirteenth at the age of eighty-seven. He had retired from practice. Doctor Beatty was a graduate of the Miami Medical College, in Cincinnati, in 1881, and had practiced nearly sixty years in Montgomery County.

Dean Thomas Verplank, M.D., of Gary, died May twenty-seventh, at the age of thirty-one. He was a graduate of Indiana University School of Medicine, in 1943, and had practiced in Gary for approximately eighteen months. Doctor Verplank was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Charles L. Smullen, M.D., of Rushville, died on May fourteenth after a two-month illness. He was eighty-one years of age. Doctor Smullen was the oldest practicing physician in Rush County. He was a graduate of the Medical College of Indiana, in Indianapolis, in 1889. Doctor Smullen was a member of the Rush County Medical Society, and the American Medical Association, and an honorary member of the Indiana State Medical Association.

Robert M. Hedrick, M.D., of Gary, died suddenly on May twentieth just as he had completed an operation. He was fifty-six years of age. Doctor Hedrick was a graduate of the Meharry Medical College, in Nashville, in 1918, and had practiced in Gary since 1920, limiting his practice to surgery. He was a member of the Lake County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Moritz Bachrach, M.D., of South Bend, died at his home on May seventh. He was fifty-eight years of age. Doctor Bachrach was born in Germany, and received his medical education there at the Universitat Heidelberg Medizinische Fakultat, Baden. He came to South Bend in 1938 and had practiced there since that time. Doctor Bachrach was a member of the St. Joseph County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Allen J. Hylton, M.D., of Mooresville, died at the age of eighty-four on May eighteenth. A graduate of the Medical College of Indiana, in Indianapolis, in 1901, Doctor Hylton had practiced in Mooresville for forty-five years.

George E. Martin, M.D., of Williamsburg, died on May sixteenth at his home. He was seventy years of age, and had retired from practice. Doctor Martin was a graduate of the Louisville Medical College in 1903, begining his medical studies after serving in the Spanish-American War.

Bird Allen Tracy, M.D., of Hudson, died on April sixth in Cleveland, Ohio, where he had lived since his retirement two years ago. He was eighty years of age. Doctor Tracy was a graduate of the Baltimore University School of Medicine, in Baltimore, Maryland, in 1891, and had practiced in Hudson since 1917.

Wendell D. Little, M.D., of Indianapolis, died at his office on May twenty-fourth. He was fifty-four years of age. A graduate of the Indiana University School of Medicine in 1918, Doctor Little specialized in surgery. He was a veteran of World War I. He was a member of the American College of Surgeons, the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

John D. McLeay, M.D., of Indianapolis, died on May twenty-third after fifty-two years of practice in Indianapolis. He was seventy-three years of age. Doctor McLeay was a graduate of the University of Western Ontario Medical School, at London, Ontario, in 1894, and specialized in bacteriology. He was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.

Charles C. McArdle, M.D., of Monroeville, died on April seventeenth at the age of fifty-five. He was a graduate of the Indiana University School of Medicine, in Indianapolis, in 1923, and had practiced in Monroeville for ten years, having practiced previously in Anderson. During World War I, Doctor McArdle served as a lieutenant under General MacArthur; and during World War II, he was active in civilian defense. Doctor McArdle was a member of the Allen County Medical Society, the Indiana State Medical Association, and the American Medical Association.

News Notes

Dr. Holland Thompson, who has been Director of the Division of Tuberculosis Control at the Indiana State Board of Health, in Indianapolis, has accepted a position as Coordinator of Medical Services at the Irene Byron Sanatorium, in Fort Wayne.

Dr. C. N. Fischer, of La Porte, has purchased a residence in La Porte, and has established his practice there as physician and surgeon. Doctor Fischer went to La Porte four and one-half years ago, as medical director of the Kingsbury Ordnance plant, in which capacity he remained until the first of the year.

Announcement was made recently of the appointment of Dr. C. G. Kern, of Lebanon, as city health officer, succeeding Dr. O. C. Higgins, of Lebanon, who resigned on June first. Doctor Higgins had been the health officer for many years. Doctor Kern will serve also as secretary of the Lebanon Board of Health.

Dr. and Mrs. Chester A. Stayton, of Indianapolis, recently visited with their daughter and son-in-law, Dr. and Mrs. James C. Katterjohn, in Philadelphia, Pennsylvania; Dr. Katterjohn being a resident at the University of Pennsylvania. Incidentally, the Staytons are the proud grandparents of a grandson, Michael Bruce, born to Dr. and Mrs. Chester Stayton, Jr.

Announcement has been made of the marriage of Miss Julia Louise Guess, daughter of Mrs. Lawrence L. Guess, of Indianapolis, and Dr. Basil B. Dulin, of Indianapolis, which took place on May twenty-sixth in the chapel of the First Presbyterian Church, at Indianapolis, with the Reverend Russell W. Galloway officiating. Doctor Dulin is a graduate of the Indiana University School of Medicine. He recently returned from the Pacific Theatre, where he served with the United States Army Medical Corps, and has accepted a Fellowship in Medicine at the Indianapolis City Hospital.

Dr. Homer L. Burke, of Bremen, together with his family, have gone to Castaner, Puerto Rico, where Doctor Burke will be in charge of a rural hospital which serves a population of thirty thousand people who have no other means of obtaining medical aid. Doctor Burke and his family expect to remain in Puerto Rico for two years. Dr. Otis Bowen, a graduate of the Indiana University School of Medicine, plans to take charge of Doctor Burke's office. Doctor Bowen recently was released from the Army Medical Corps, having served for three years on Okinawa.

At the annual meeting of the Shelby County Tuberculosis Association held recently in Shelbyville, Dr. J. E. Keeling, of Waldron, was named president. Dr. R. M. Nigh, of Fairland, was appointed to the Board of Directors for a three-year term.

Dr. Elmer G. Koehler and Mrs. Ada Snellenberger, both of Elkhart, were married on June first, in Columbia City, where Doctor Koehler practiced before going to Elkhart. The Reverend G. L. Kleespie, of the Grace Lutheran Church, performed the ceremony.

The Indiana Roentgen Society held its annual meeting at the Columbia Club, in Indianapolis, on May twelfth, when Dr. Lester G. Erickson, of South Bend, was elected president. The speakers on the program included Dr. L. E. Burney, of Indianapolis, state health commissioner, and Dr. Carleton B. Peirce, of the Royal Victoria Hospital, in Montreal, Quebec, Canada. Members of the society who have returned from the armed services were given a welcome at the dinner in the evening.

PIONEER PHYSICIANS FETED

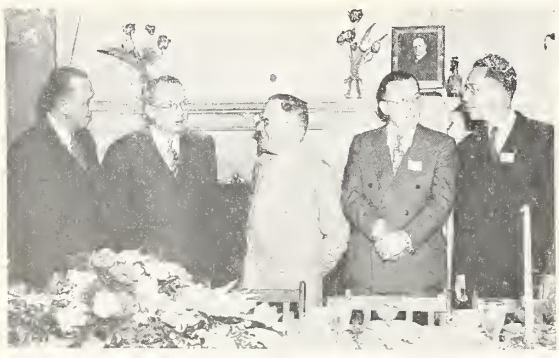
Wayne County's three oldest physicians, Dr. Charles S. Bond, of Richmond; Dr. Marcus L. Meek, of Abington; and Dr. Joseph N. Study, of Cambridge City, were honored by the Wayne-Union County Medical Society at a meeting held at the Leland Hotel, in Richmond, on June thirteenth. Dr. Study being unable to attend the dinner, a reunion of the three "octogenarians" was arranged at the home of Dr. Study, where this photograph was taken, and where their memories turned back some ninety years. (For further details of the trio's celebration, see County Society Reports on page 376.)



(Courtesy *The Paladium-Item*)

Left to right: Dr. Charles S. Bond, Dr. Marcus L. Meek, and Dr. Joseph N. Study.

NINTH COUNCILOR DISTRICT CELEBRITIES



Left to right: Dr. John R. Porter, of Lebanon; Allan Saunders, of Toledo, Ohio; Dr. Floyd T. Romberger, of Lafayette; Dr. Wemple Dodds, of Crawfordsville; and Dr. Charles O. Weddle, of Lebanon.

The Ninth District Medical Society did things up in grand style at its meeting held at the Ulen Country Club, in Lebanon, on May seventh, as noted from this photograph taken at the banquet, at which Allan Saunders, of Toledo, Ohio, was the guest speaker. "Philosophy of Humor" was the theme of his talk. He tore humor apart and put it together again, with humor flowing freely throughout his discourse. For further information concerning the district meeting, see Society Reports on page 378.

Two Indianapolis physicians were elected to offices in the Indiana Tuberculosis Association at its annual meeting, in Indianapolis, on May 8 and 9. Dr. Frank L. Jennings was elected first vice-president, and Dr. Charles J. McIntyre was elected treasurer. Dr. McIntyre was also elected treasurer of the Indiana Trudeau Society, which is the medical section of the association.

The Caylor-Nickel Clinic, of Bluffton, has added Dr. Robert Lee Johnston, formerly of Ohio, to its staff, specializing in internal medicine and gastroscopy. Doctor Johnston spent four and one-half years in the service, and since his release, in January, 1946, he has taken courses at the Cleveland Clinic, the Harvard Medical School, and the University Hospital at Ann Arbor, Michigan.

"COURAGE AND DEVOTION BEYOND THE CALL OF DUTY"

Thirty-four thousand dollars in War Bonds are being offered to physician-artists, through the cooperation of Mead Johnson & Company, (both in civilian and in military service) for art works best illustrating the above title.

This contest is open to members of the American Physicians Art Association and will be judged in June, 1947, at the Atlantic City Session of the American Medical Association. For full details, write Dr. F. H. Redewill, Secretary, Flood Building, San Francisco, California, or Mead Johnson & Co., Evansville 21, Indiana.

Approximately twenty physicians and their wives paid tribute to Dr. Eva Kennedy, of Camden, at a dinner given in her honor recently, in observance of the fortieth anniversary of her graduation from the Indiana Medical College. She went to Camden about a year and a half following her graduation, and has continued her practice there since that time.

Dr. O. E. Brendel, of Zionsville, is retiring, after thirty-five years of practice in that community. Doctor Brendel began the practice of medicine in 1907 with his father, Dr. J. F. Brendel. This was prior to the automotive age, and the physicians usually relied upon one or two teams of horses in making their calls. He bought his first car in 1912, but even then had to keep horses, due to the condition of the roads in bad weather. Medicine and surgery have made wonderful strides in his time, with continued progress. Doctor Brendel plans to spend his leisure time in overseeing his farms, northeast of Zionsville, and in fishing at his cottage at a lake in Michigan.

DR. WALTER F. KELLY HONORED BY INDIANAPOLIS MEDICAL SOCIETY

More than one hundred sixty members and friends of Dr. Walter F. Kelly, of Indianapolis, assembled at the Athenaeum on the night of June fourth to pay deserving tribute to Doctor Kelly, who has retired from practice after almost forty years of service in Irvington, and who is now residing at New Milford, Connecticut. Doctor Kelly had come to attend this "Victory Jubilee Dinner," which to his surprise turned out to be a dinner in his honor. Victory it was, for in those four decades of practice Doctor Kelly has given unstintingly of his service and has left a career behind him such as few men achieve. A Jubilee it also was, for Doctor Kelly was revered by everyone, who on this occasion shared with him in the joy of seeing his ambition fulfilled—that of "living the real life," as he termed it in referring to his beloved New England home where he can now retire to a simple life on a seventy-acre farm.

The main feature of the evening was an address by Indiana University's Alvin N. (Bo) McMillen, whose laugh-provoking address was in keeping with Doctor Kelly's life and prowess as a star end on the Dartmouth eleven of 1895 and 1896, and his subsequent athletic directorships at Texas and Butler Universities.

Doctor Kelly was presented with an attractive parchment scroll signed by the officers of the Indianapolis Medical Society, which stated in part that he had "served the organization with distinction and reflected credit on the profession"; also a large traveling bag, and a diamond-studded past-commander's pin from the Paul Coble American Legion Post, as a tribute from his host of Indianapolis friends.

The forty-second annual reunion of the class of 1904 was held on April 22 and 23, at the Indiana University School of Medicine, in Indianapolis, when a banquet was given at the Columbia Club. Fifteen members of the class were present, in addition to two of the professors, one of whom is eighty-two years of age, and still a practicing physician.

INDIANA SPONSORS INSTITUTE ON GERIATRICS

A one-day institute on "Geriatrics," sponsored by the Indiana State Board of Health and the Indiana University School of Medicine, was held in the medical school auditorium, in Indianapolis, on May twenty-second. This institute, believed to be the first of its kind in the nation, was the outgrowth of the work of Dr. William F. King, who is head of the Board of Health's new Department on Geriatrics and Adult Hygiene.

Dr. W. D. Gatch, dean of the medical school, presided at the morning session, and presented the following speakers, all of whom were from Indianapolis: Dr. William F. King, whose subject was "Health Guidance"; Dr. C. L. Williams, director of the Indiana Council for Mental Health, who spoke on "Mental Hygiene and Geriatrics"; Dr. R. A. Solomon, who spoke on "Cardiovascular-renal diseases"; Dr. William V. Woods, who discussed "Arthritis"; Dr. John L. Arbogast, who spoke on "Cancer"; Dr. Robert J. Masters, who spoke on "Diseases of the Eye"; and Dr. Clyde G. Culbertson, who discussed "A. C. S. (Bogomolets' Serum)."

The afternoon session was presided over by Dr. L. E. Burney, state health commissioner, who introduced the guest speaker, Dr. Edward J. Stieglitz, consultant in gerontology, National Institute of Health, Washington, D.C., who spoke on "Geriatric Medicine." Mr. C. N. Smith, assistant personnel director of the Indiana Bell Telephone Company, spoke on "Management's Responsibility in Industrial Health," and Dr. Fred B. Wishard, of Anderson, discussed "Medical Responsibility in Industrial Health." At the close of the program Doctor Gatch summarized the papers and discussions.

INDIANA UNIVERSITY NEWS NOTES

Acceptance of 128 students, all but six from Indiana and including ten women, for admission in September to the Indiana University School of Medicine was announced following the annual meeting of the school's fourteen-member Admissions Committee.

The class of 128, which is the maximum that can be accommodated by the school's facilities, represents the final selection from almost one thousand candidates. The Admissions Committee, composed entirely of physicians, was headed by Dr. C. H. McCaskey, of Indianapolis.

The class as chosen is composed largely of war veterans and includes the following: Robert M. Abel, Elkhart; Robert H. Addleman, South Bend; Otho V. Andrews, Decatur; Carl H. Ault, Winamac; Ernest A. Baade, Fort Wayne; Bertram Baker, Indianapolis; Herbert E. Baumeister, Indianapolis; Bernard C. Berger, Indianapolis; Frederick W. Bigler, Goshen; James H. Bivin, Indianapolis; Ben E. Black, Alexandria; Mariam Elizabeth Blackburn, Lafayette; Maurice K. Borklund, Morocco; John J. Brandon, Culver; William F. Briscoe, Indianapolis; Herbert C. Bronnenberg, Anderson; Lewis Brooks, Brooklyn, New York; Cecil R. Buchanan; Anderson; Cecil R. Burket, Osceola; Patrick B. Campbell, Indianapolis; James P. Cloud, Orleans; Robert W. Cochran, Mishawaka; Avery L. Goddens, Mishawaka; Walter H. Cory, Hagerstown; Robert M. Cullen, Evansville; Wilson L. Dalton, Bloomington; Dale A. Davidson, West Terre Haute; Harold C. Day, Tipton; Jack H. Demlow, Indianapolis; James E. Dill, Pendleton; Paul W. Elliott, Indianapolis; George K. Faulkner, Fort Wayne; Richard B. Feiertag, Fort Wayne; Elsie Flint, Wolcottville; Harold Fosgate, Indianapolis; Jean Franklin, Bloomington; Warren S. Freeborn, Marion; Gertrude Freed, Terre Haute; Bill Freeland, Indianapolis; Charles H. Frie, Fort Wayne; Vernon L. Fromang, Evansville; Richard Garton, Fort Wayne; John W. George, Indianapolis; Neal A. Goldsmith, Grabill; Merlyn A. Grant, Marion; Frederic A. Gronau, Fort Wayne; Kenneth A. Grow, Indianapolis; James U. Guthrie, Logansport; Jack L. Hargan, Fort Wayne; D. Kent Hassan, Middlebury; Ruth Heath, Gary; William R. Hiatt, Bluffton; Richard E. Hipskind, Fort Wayne; Harry W. Hoegemeier, Gary; John L. Holmes, Frankfort; Ralph L. Hopp, North Manchester; Donn R. Hunter, Converse; Jean Johnston, Indianapolis; Isadore Katz, Detroit, Michigan; William S. Keezer, Vincennes; William A. Kleifgen, Indianapolis; Marvin L. Komisarow, Fort Wayne; William B. Kriel, Indianapolis; Leonard Kurland, East Chicago; Francis L. Land, Anderson; James M. Lawson, Muncie; Edgar R. Leach, Chesterton; George W. Leonard, Jr., Elkhart; Richard S. Lewis, Terre Haute; Howard M. Luginbill, Berne; Glenova McClure, Sullivan; Warren A. McGaughey, Crawfordsville; Francis M. Maple, Rushville; Charles F. Marks, Indianapolis; Carl M. Marsh, Huntington; Charles R. Mather, Lafayette; Beverly T. Maxam, Indianapolis; Daryl M. Miller, Morgantown; Donald C. Miller, Indianapolis; Milton H. Miller, Indianapolis; William A. Misch, Gary; Edward O. Mitchell, Indianapolis; Michael O. Monar, Indianapolis; Katherine Moore, Indianapolis; Robert W. Moses, Fort Wayne; Herschel C. Moss, Indianapolis; Charles R. Myers, Goshen; Paul E. Myers, Urbana; Dennis Nicholas, Rockville; Jerald L. Noffsinger, Union City; Donald T. Olson, South Bend; Theodore C. Person, Gary; Edward J. Ponczek, LaPorte; Francis W. Price, Indianapolis; Harvey J. Reamy, Summitville; Arthur L. Reed, South Bend; Raymond L. Reed, Indianapolis; John W. Roll, Indianapolis; Thomas K. Rollins, Royal Center; Robert L. Ross, Union City; Leo Roth, Gary; Junior Max Rukes, Rosedale; George M. Ruston, Evansville; Hadassah Samuels, Chicago, Illinois; William D. Scharbrough, Bedford; Will E. Scott, Jr., Marion; Sheldon T. Selesnick, Detroit, Michigan; Eugene F. Senseny, Fort Wayne; Morris J. Shenk, Scottsburg; Mrs. Priscilla Shenk, Scottsburg; Samuel Slipp, Newark, N. J.; Bill B. Smiley, Fort Wayne; Stanley Spellman, Jamaica, New York; Hugh Spencer, Franklin; Charles A. Stanley, Anderson; Lloyd K. Stump, Indianapolis; Edwin E. Stumpf, Fort Wayne; Donald W. Tharp, Trafalgar; John T. Toppen, DeMotte; Frank C. Waltz, Hagerstown; Howard R. Wetzel, Fort Wayne; Douglas H. White, Jr., Indianapolis; Charles F. Wible, Jr., Seymour; David Wilson, Evansville; Rex L. Winchell, Rockport; Leslie C. Wolfe, Terre Haute; James A. Work, Elkhart, and Richard H. Worley, Indianapolis.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

EXECUTIVE COMMITTEE

June 2. 1946

Roll call showed the following present: Cleon A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. M. Mitchell, M.D.; A. F. Weyerbacher, M.D; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guests: N. M. Beatty, M.D.; J. William Wright, M.D.; N. K. Forster, M.D.; W. H. Howard, M.D.; W. L. Portteus, M.D.; F. S. Crockett, M.D.

Membership Report

Number of members May 31, 1946	3,339*
Number of members May 31, 1945	3,182
Gain over last year	157
Number of members December 31, 1945	3,396

* Includes 331 veterans, 804 in military service, and 154 honorary members.

Statements of receipts and expenditures for April and May for the association committees and THE JOURNAL were approved.

Actions to Be Taken as Result of 1945 House of Delegates Meeting

The president reported that a conference with the presidents of the State Bar and State Dental Associations would be arranged in the near future and that it was his desire that the president-elect, chairman of the Council, chairman of the Executive Committee, and the executive secretary attend the dinner.

Administrative chart. An administrative chart, showing the organization of the association, prepared at the direction of the House of Delegates, was submitted by the executive secretary and approved and ordered published in the July JOURNAL, on motion of Dr. Mitchell, seconded by Dr. Ferrell.

1946 Annual Session, Indianapolis, October 29, 30, 31, 1946

Scientific program.

(a) *Instructional courses*

1. On motion of Dr. Mitchell, seconded by Dr. Romberger, the Executive Committee approved the action of the Committee on Scientific Work in eliminating the $1.00 admission charge to the 1946 instructional courses.

2. *Instructional course committee.* On motion of Dr. Mitchell, seconded by Dr. Ferrell, the Executive Committee voted to recommend to the House of Delegates that the Committee on Scientific Work each year name a subcommittee to handle the instructional courses.

(b) *Motion picture exhibit.* The Executive Committee sustained the action of the Committee on Scientific Work in establishing a motion picture program at the annual session, with the provision that no films be exhibited which do not have the approval of the American Medical Association.

Contract with Murat Temple. The contract with the Murat Temple was approved on recommendation of the attorney, and the executive secretary was instructed to sign it.

Legislative Matters

National

Wagner-Murray-Dingell bill. The committee discussed the present status of the bill, and expressed appreciation for the bulletins sent out by Dr. J. S. Lawrence, director of the Washington Office of the A.M.A. Council on Medical Service and Public Relations, on the hearings on this bill.

Taft bill, S. 2143. Provisions of this bill were discussed by the president of the association. He expressed the belief that the House of Delegates of the American Medical Association would take some official action on this bill.

EMIC program. The executive secretary reported that the Indianapolis Medical Society had adopted a resolution opposing the continuation and broadening of the EMIC program.

Local

Legislative bulletin. A legislative bulletin, urging the county medical societies to meet with their legislative candidates during the summer, is to be mailed within a few days.

Prepayment Medical Care

Mutual Medical Insurance, Inc.

Services to be covered in contract. Just as soon as it is feasible, it was the judgment of the Executive Committee that the certificate of the Mutual Medical Insurance, Inc., include all medical services which are now incorporated in the Blue Cross contract.

National plan. It was reported that thirty-three states now have medical care plans in operation and eight states are working toward that end.

Veterans Administration agreement. No word has been received from the Veterans Administration on its acceptance or rejection of the contract submitted by the Veterans Affairs Committee of the Indiana State Medical Association.

Organization Matters

Indiana Board of General Practice of Medicine, Inc. Report made that fifty-three applications have been received and that the incorporation papers would be filed as soon as one more signature is procured.

Centennial meeting of the Ohio State Medical Association. Differences in operation of the annual session and organization of the Ohio State Medical Association and the Indiana State Medical Association were mentioned by the executive secretary.

Membership signs. The question of offering membership signs to each member of the association was referred to the Council.

State Board of Medical Registration and Examination

Annual Registration Law. The Committee on Public Policy and Legislation of the state medical association was directed to carry out the wishes of the House of Delegates that a $2.00 annual registration bill be prepared and introduced in the 1947 General Assembly. The attorney offered his services to the legislative committee in drafting this bill.

Rural Health

Dr. F. S. Crockett appeared before the committee and gave a report on the Rural Health Day Conference which is to be held at Purdue University in late July or early August.

Following a discussion by Dr. Crockett, the committee approved the policy of the Midwestern Agricultural Workers' Health Association, Inc., of contacting county medical societies to arrange for medical care of agricultural workers of foreign birth.

The Journal

Increase in printing costs. It was reported that word had been received from C. E. Pauley and Company, Inc., that an increase of 16 per cent in composition charges, effective June 1, would increase the cost of each issue of THE JOURNAL approximately $70 to $80.

There being no further business, the meeting was adjourned.

BUREAU OF PUBLICITY

May 2, 1946

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D.; Mrs. Lotys Benning Stewart, publicity and radio script writer, and Ray E. Smith, executive secretary.

The following news releases for the "Hints on Health" column going to weekly newspapers were approved:

Week of May 6, 1946—"Impaired Hearing in Children."

Week of May 13, 1946—"Rheumatic Fever."

The following news releases for daily newspapers were approved:

May 13, 1946—"Watch Children's Ears."

May 20, 1946—"Gardening."

The secretary reported that the Indiana State Board of Health was working on new copy for the booklet entitled, "Information Regarding the Prevention of Contagious Diseases."

There was general discussion of a suggested Woman's Auxiliary program for 1946-47. The secretary was instructed to draft an outline for twelve meetings and present it to the bureau for consideration at its next meeting.

BUREAU OF PUBLICITY

May 20, 1946

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The following news releases for the "Hints on Health" column going to weekly newspapers were approved:

Week of May 20—"Prevention of Lockjaw."

Week of May 27—"Athlete's Foot."

Week of June 3—"Dangers from Underweight."

The following news releases for daily newspapers were approved:

May 27—"Time for Sunburn."

June 3—"Watch Out! It's Summer!"

June 10—"Diabetes."

The ten suggested programs for the Woman's Auxiliary were submitted to the bureau by the executive secretary, and approved. The secretary was directed to mail these to the 1946-47 program chairman of the Woman's Auxiliary.

The executive secretary reported that Radio Station WFBM had agreed to use recordings from the American Medical Association after the "Ladies, Your Health" program is discontinued at the end of May. A list of recordings which are available is to be submitted to the radio station for its selection.

LOCAL SOCIETY REPORTS

Fayette-Franklin County Medical Society members held a meeting at Mound Camp, in Brookville, on June eleventh. Twenty-three members and guests attended.

Boone County Medical Society members held a meeting at the Witham Memorial Hospital, at Lebanon, on June fourth. Dr. Wemple Dodds, of Crawfordsville, Councilor of the Ninth District, spoke briefly on the newly-organized Mutual Medical Insurance, Inc., and two other guests, Drs. W. D. Close, and A. D. McKinley, of Indianapolis, spoke informally on "Electrocardiography."

Cass County Medical Society members met on May seventeenth at the Cass County Hospital, at Logansport, to hear Dr. C. R. Donham, professor of Veterinary Science, Purdue University, who spoke on "Diseases Common to Animal and to Man." Twenty members attended the meeting.

Clinton County Medical Society members met at the Clinton County Hospital, at Frankfort, on June fourth. The guest speaker was Dr. Floyd T. Romberger, of Lafayette, President-elect of the Indiana State Medical Association, who discussed "Socio-Economic Problems of the County Medical Society." Eleven members were present.

Delaware-Blackford County Medical Society members held a meeting at the Hotel Roberts on May twenty-first. A talk on "German Military Hospitals" was given by Dr. M. J. Moss, of Yorktown. Twenty-five members attended the meeting.

Floyd County Medical Society members held a meeting at the New Albany Country Club on May tenth. The twenty-two members present participated in a forum on "Public Health in Floyd County."

Fort Wayne (Allen County) Medical Society members met at Fort Wayne on May seventh to hear Dr. Milton Tinsley, of the University of Illinois, speak on "Head and Back Injuries." Doctor Tinsley illustrated his talk with lantern slides. Fifty-five members were present.

One hundred members were present at the annual business meeting and election of officers on May twenty-first. This meeting was held at the Chamber of Commerce, in Fort Wayne.

Gibson County Medical Society members met on May thirteenth at the Hotel Emerson in Princeton. Dinner was served to the twelve members and guests present. A very interesting talk was given by Dr. H. C. Ruddick, of Evansville, on "Surgery of the Gall Bladder." The society has resumed its regular meetings, on the second Monday of each month.

Another meeting was held on June tenth, at the Emerson Hotel, in Princeton, which was attended by seventeen members and guests. Dr. Pierce MacKenzie, of Evansville, spoke on "Conservative Gynecological Surgery," and a general discussion followed his talk.

Greene County Medical Society members held their last meeting until fall on May sixteenth. This was a business and dinner meeting, and was held at the Freeman Greene County Hospital, at Linton. Fourteen members were present.

Lake County Medical Society members met at the Indiana University Extension Center, in East Chicago, for a meeting on April eleventh. The speakers were Drs. Frank J. Kendrick, and C. P. Anderson, both of Gary. They spoke on "Ringworm of the Scalp." Seventy-five members attended the meeting.

Madison County Medical Society members were guests of the Mercy Hospital staff, at the Elwood Country Club, in Elwood, on May twenty-first. Eighty members and guests attended the dinner, which followed an afternoon of golf. Guest speaker of the evening was Dr. E. Perry McCullagh, of Cleveland, Ohio.

Wayne-Union County Medical Society members held a meeting unique in Indiana county medical society annals, at Richmond, on June thirteenth. It was an "Octogenarian Celebration" with Dr. Charles S. Bond, aged ninety, of Richmond, as honor guest; and Dr. J. N. Study, aged ninety-five, of Cambridge City; and Dr. M. L. Meek, aged ninety, of Abington, as special guests.

The ages of the three Wayne County physicians aggregate two hundred seventy-five years. As far as is known, no other county in the state has three doctors ninety years old, or older. Dr. Study adheres to a schedule of retiring early, and therefore was unable to attend the dinner at the Leland Hotel.

The principal speaker was Dr. George S. Bond, of Indianapolis, professor of Cardiology at the Indiana University School of Medicine, and son of the honor guest. Of the many things for which he is indebted to his father, said Doctor Bond, is an ideology of medicine that he learned from him while riding with him on his house calls. The son told of his father's appetite for research in the field of tuberculosis and his experiments with the early x-ray. He concluded his remarks with a lecture on "Heart Failure and Its Management."

A biography of Doctor Bond who, incidentally, was president of the Indiana State Medical Association in 1895, was read by Dr. F. E. Hagie, chairman of the program. References were made to Dr. Study and Dr. Meek.

Ray E. Smith, executive secretary of the Indiana State Medical Association, extended congratulations and best wishes to the three doctors on behalf of Indiana Medicine.

Dr. Walter U. Kennedy, councilor of the sixth district, and three other New Castle doctors attended the meeting.

At another meeting, on May ninth, at the Coliseum, in Liberty, the members held their annual meeting. Dinner was served by women of the Salem Church. The members' wives were guests at this meeting, and there was an attendance of fifty-four.

Montgomery County Medical Society members met on April eighteenth, at the Culver Hospital, in Crawfordsville, for a dinner meeting. Dr. L. G. Montgomery, of Muncie, spoke on "The Rh Blood Factor," accompanying his discussion with a series of very interesting as well as amusing lantern slides. Twenty-seven members and guests attended the meeting.

Another meeting was held on May sixteenth at the Culver Hospital, in Crawfordsville. The guest speaker was Dr. J. O. Ritchey, of Indianapolis, whose subject was "Bright's Disease." Twenty-four members and guests attended the meeting.

Randolph County Medical Society members held a meeting on June ninth, in Winchester, with eight members present. A general discussion was held concerning the need of a new Randolph County hospital.

Tippecanoe County Medical Society members held a meeting at the Lincoln Lodge on May fourteenth. The speaker was Dr. John F. Spahr, of Indianapolis, whose paper on "Caudal Anesthesia," was followed by a discussion. Fifty members attended this meeting.

At another meeting in Lincoln Lodge, on June eleventh, Dr. James F. Balch, of Indianapolis, was the guest speaker. His subject was "The Almighty Gonococcus." Forty members attended.

COUNCILOR DISTRICT MEETINGS

FIRST COUNCILOR DISTRICT

The First Councilor District meeting was held in conjunction with the May meeting of the Vanderburgh County Medical Society, on May fourteenth, at the McCurdy Hotel, in Evansville. Dr. A. F. Marchand, of Haubstadt, president of the First Councilor District, presided, and introduced Dr. Jesse E. Ferrell, of Fortville, president of the Indiana State Medical Association, who spoke on problems confronting the medical profession today; and Mr. Ray E. Smith, of Indianapolis, executive secretary of the Indiana State Medical Association, who extended greetings from the association. The scientific address of the program was given by Dr. J. Grey Jones, of Saint Louis, Missouri, whose subject was "Diagnosis and Treatment of Chronic Pelvic Inflammation." Dr. Jones was introduced by Dr. C. A. Hartley, Jr., of Evansville, president of the Vanderburgh County Medical Society.

New officers for 1947 were elected, as follows: President, Dr. William M. Cockrum, Evansville; Vice-president, Dr. George Willison, Evansville; Secretary-treasurer, Dr. Virgil McCarty, Princeton.

Seventy-seven members and guests were present.

SECOND COUNCILOR DISTRICT

The Second Councilor District Medical Society meeting was held on June fifth at the Sullivan Hotel, in Sullivan, with the Sullivan County Medical Society as its host.

Following a business session, a color film was shown, on "Diagnosis and Treatment of Cancer of the Female Breast," and a multi-colored film was presented on "A Trip through South America."

Dr. K. L. Hull, of Bloomfield, was retained as president, and Dr. J. S. Brown, of Carlisle, was retained as secretary. Greene County was selected as the meeting place for the next meeting. No action was taken regarding the election of a Councilor, since some counties were not represented, and Dr. J. H. Crowder, of Sullivan, will accordingly continue as councilor. Thirty-five members and guests were present.

THIRD COUNCILOR DISTRICT

Dr. A. P. Hauss, of New Albany, was re-elected councilor of the Third Councilor District at a meeting held on May twenty-second, at Spring Mill State Park, near Mitchell. More than sixty physicians were present.

Dr. Hauss submitted his resignation so that Dr. William H. Garner, of New Albany, whom he succeeded when Dr. Garner entered military service, might be reinstated as councilor. However, Dr. Garner refused and made the motion that Dr. Hauss be re-elected to the three-year term.

A report by Dr. Hauss on problems of the medical profession, including many constructive suggestions, was enthusiastically received.

Dr. Walter U. Kennedy, of New Castle, president of Mutual Medical Insurance, Inc., the company organized to write prepayment medical care insurance in Indiana, explained the evils of the Wagner-Murray-Dingell Bill and the purpose of the new insurance company. Ray E. Smith, of Indianapolis, executive secretary of the Indiana State Medical Association, spoke briefly. The scientific program consisted of a lecture on "Diabetes," by Dr. John H. Warvel, of Indianapolis.

Dr. Percy R. Pierson, of New Albany, was elected president of the Third District Medical Society, and Dr. William F. Edwards, also of New Albany, was elected secretary-treasurer. The members voted to meet only once a year in the future and selected New Albany as the next meeting place.

Dr. Claude Dollens, of Oolitic, and Dr. Roland E. Wynne, of Bedford, were the retiring president and secretary-treasurer of the society, respectively.

FOURTH COUNCILOR DISTRICT

The annual meeting of the Fourth Councilor District Medical Society was held in Columbus, on May twenty-ninth. A golf tournament was held in the morning, and a bridge party and tea was given for the ladies during the afternoon, while the doctors attended the business session. Speakers on the afternoon program were Dr. J. O. Ritchey and Dr. L. E. Burney, both of Indianapolis. The speaker for the banquet, which was held in the Chamber of Commerce, was Dr. Jesse E. Ferrell, of Fortville, president of the Indiana State Medical Association. Dr. Lowell F. Beggs, of Columbus, presided in the absence of Dr. R. B. Hart, of Columbus, who could not be present due to illness in his family.

Officers elected for the coming year were as follows: President, Dr. L. H. Osterman, Seymour; Vice-president, Dr. George S. Row, Osgood; Secretary-treasurer, Dr. H. P. Graessle, Seymour. Registration numbered fifty.

FIFTH COUNCILOR DISTRICT

Dr. Richard S. Bloomer, of Rockville, was elected president of the Fifth District Medical Society for 1947, at the annual meeting held in Terre Haute, on June fifth.

Dr. Dick J. Steele, of Greencastle, was elected vice-president, and Dr. M. C. Topping, of Terre Haute, was re-elected secretary. Drs. Bloomer and Steele are veterans of World War II.

In an address at the banquet, Dr. Floyd T. Romberger, of Lafayette, president-elect of the Indiana State Medical Association, warned of the influences at work to regiment the medical profession and urged the physicians to take more interest in the established medical organizations. Ray E. Smith, executive secretary of the state association, also spoke. Dr. J. F. Spigler, of Terre Haute, district president, served as toastmaster.

In the afternoon the following scientific program was presented: "The Pre- and Post-operative Care of Common Abdominal Conditions," by Dr. Jacob K. Berman, of Indianapolis; "The Use of Plasma and Blood Transfusions with Observations of RH Factor," by Dr. Clyde G. Culbertson, of Indianapolis; and "The Present Status of Thiouracil," by Dr. Cyrus J. Clark, of Indianapolis.

SIXTH COUNCILOR DISTRICT

Meeting at Mounds Camp, south of Brookville, on May twenty-third, the Sixth District Medical Society re-elected Dr. Walter U. Kennedy, of New Castle, as councilor for another three years.

The society officers have two more years to serve on their terms. They are Dr. Will A. Thompson, of Liberty, president; Dr. Clifford E. Canaday, of New Castle, vice-president, and Dr. Perry A. Campbell, of Richmond, secretary.

The scientific program consisted of lectures by Dr. Earl Mericle, of Indianapolis, on "Combat Exhaustion As Applied to Civilian Practice"; "Dermatology in General Practice," by Dr. A. L. Welsh, of Cincinnati; and "Diagnosis and Management of Intestinal Lesions," by Dr. J. K. Berman, of Indianapolis.

Other speakers include Dr. Jesse E. Ferrell, of Fortville, president of the Indiana State Medical Association, and Dr. Kennedy. Ray E. Smith, executive secretary of the state association, was also present at the meeting.

EIGHTH COUNCILOR DISTRICT

Dr. E. H. Clauser, of Muncie, was re-elected councilor of the Eighth District at a meeting of the Eighth District Medical Society at the Delaware Country Club, near Muncie, June 12.

Dr. Forrest E. Keeling and Dr. Homer F. Streib, both of Portland, were elected president and secretary, respectively, of the society. The Jay County Medical Society will be host to the district meeting in 1947.

Ray E. Smith, executive secretary of the Indiana State Medical Association, was a guest and spoke briefly. Dr. Clauser gave a report as councilor.

The scientific lecture was delivered by Dr. David A. Boyd, Jr., of Indianapolis. His subject was "General Survey of Psychosomatic Medicine."

The dinner meeting was attended by approximately seventy-five members.

NINTH COUNCILOR DISTRICT

The Ninth Councilor District Society of the Indiana State Medical Association met at the Ulen Country Club, in Lebanon, on May 7, 1946.

A golf tournament was held during the morning, and in spite of cold, rainy weather there were twenty-one participants. Golf prizes were awarded.

At noon a luncheon was held for the doctors and their wives, and following this a business meeting was held by the presidents, secretaries, and delegates of the counties in this district. Dr. Charles O. Weddle, of Lebanon, president of the Ninth District, presided and extended a cordial welcome to the delegates.

Dr. Wemple Dodds, of Crawfordsville, was elected councilor for a three-year period, and commended Dr. Floyd T. Romberger, of Lafayette, the President-elect of the Indiana State Medical Association, upon his excellent record during his service as councilor for the past sixteen years.

Doctor Dodds discussed in detail the new Mutual Medical Insurance, Inc., and stated that everything was all set and that they were ready to go.

Doctor Weddle next called for a brief report from the delegates of each county. Those reporting were: Dr. H. D. Kindell, of Montgomery County; Dr. Henry W. Greist, of White County; Dr. Claude D. Holmes, of Clinton County; Dr. Verne L. Turley, of Benton County; Dr. W. A. Kurtz, of Tipton County; Dr. F. P. McDaniel, of Hamilton County;

Dr. Charles O. Weddle, of Boone County; Dr. G. A. Thomas, of Tippecanoe County; and Dr. Lee J. Maris, of Fountain-Warren Counties.

The next annual meeting of the Ninth Councilor District is to be held at Attica, on the third Thursday of May, 1947.

Dr. Romberger, as representative for Dr. J. E. Ferrell, the President of the Indiana State Medical Association, who was unable to attend, spoke briefly on the Wagner-Murray-Dingell Bill, and expressed the opinion that it will not come up at this time before Congress adjourns. He advised everyone to read the organization section of *The Journal of the American Medical Association* for the latest reports and progress on the hearings of the bill, and urged that medicine be kept under the control of the medical profession.

The scientific program, with Dr. Weddle in charge, was devoted to the subject "Penicillin." Mr. G. E. Hines, of Terre Haute, spoke on "Production of Penicillin"; and three Indianapolis physicians gave talks on the use of penicillin in their various specialties: Dr. Brandt F. Steele, on "Penicillin in Internal Medicine"; Dr. Robert D. Howell, on "Penicillin in Urology"; and Dr. Russell L. Arbuckle, on "Penicillin in Dermatology and Syphilology." A free discussion from the floor followed each talk.

The banquet in the evening was attended by one hundred twenty-five members and guests, and was highlighted by a talk given by Allen Saunders, of Toledo, Ohio, on the "Philosophy of Humor," who made his audience see that humor is a big business and who presented his subject in a most entertaining manner.

Woman's Auxiliary

to the

INDIANA STATE MEDICAL ASSOCIATION

STATE OFFICERS

President—Mrs. S. J. Petronella, East Chicago.
President-elect—Mrs. A. W. Ratcliffe, Evansville.
Councilor—Mrs. Frank M. Gastineau, Indianapolis.
First Vice-President—Mrs. C. E. Munk, Kendallville.
Second Vice-President—Mrs. C. L. Wise, Camden.
Third Vice-President—Mrs. A. B. Richter, Indianapolis.
Fourth Vice-President—Mrs. Morton Wolfe, New Albany.
Treasurer—Mrs. Wendell Kelly, Anderson.
Recording Secretary—Mrs. N. E. Allen, Greenfield.
Corresponding Secretary—Mrs. David Eisenberg, Hammond.
Parliamentarian—Mrs. Charles F. Voyles, Indianapolis.
Historian—Mrs. F. S. Cuthbert, Kokomo.

CHAIRMEN OF STANDING COMMITTEES

Archives—Mrs. J. E. Ferrell, Fortville.
Bulletin—Mrs. M. B. Gevirtz, Hammond.
Post War Service—Mrs. C. W. Dahling, New Haven.
Finance—Mrs. James W. Baxter, New Albany.
Hygeia—Mrs. R. Palmer, Gary.
Legislation, Mrs. Lester A. Smith, Indianapolis.
Press and Publicity—Mrs. Otto H. Bakemeier, Indianapolis,
Mrs. George F. Lawler, Indianapolis,
Mrs. John W. Graves, Indianapolis.
Program—Mrs. D. E. Lybrook, Galveston.
Public Relations—Mrs. Leon Blum, Terre Haute.
Physical Fitness—Mrs. A. J. VanWinkle, Valparaiso.

COUNTY PRESIDENTS

Allen—Mrs. Lawrence Shinabery, Fort Wayne.
Carroll—Mrs. Max Adams, Flora.
Cass—Mrs. C. L. Viney, Logansport.
Clark—Mrs. C. F. Hancock, Jeffersonville.
Delaware-Blackford—Mrs. A. C. Rettig, Muncie.
Elkhart—Mrs. W. A. Stauffer, Elkhart.
Floyd—Mrs. A. P. Hauss, New Albany.
Hancock—Mrs. Charles M. Gibbs, Greenfield.
Howard—Mrs. R. P. Schuler, Kokomo.
Lake—Mrs. B. W. Harris, Gary.
Laporte—Mrs. R. B. Engstrom, Michigan City.
Madison, Mrs. Florence W. Smith, Anderson.
Marion—Mrs. Emmett B. Lamb, Indianapolis.
Marshall—Mrs. M. O. Klingler, Plymouth.
Northeastern Indiana Academy of Medicine (Noble)—Mrs. H. O. Williams, Kendallville.
Porter—Mrs. E. J. DeGrazia, Valparaiso.
St. Joseph—Mrs. D. A. Bickel, South Bend.
Tippecanoe—Mrs. F. L. Pike, Lafayette.
Sullivan—Mrs. F. M. Dukes, Dugger.
Vanderburgh—Mrs. William Healy, Evansville.
Vigo—Mrs. C. R. LaBier, Terre Haute.
Wells, Mrs. Truman Caylor, Bluffton.

REPORTS OF OFFICERS AND COMMITTEES*

WAR SERVICE

Mrs. Karl M. Koons

The War Participation chairman asked for no recording of hours given in voluntary work during the year, although many continued their activities as they had before V-J Day. At the fall meeting in French Lick the auxiliaries were urged to carry on an aggressive, educational campaign concerning legislation affecting the conditions of the practice of medicine.

Following a suggestion from the national chairman in March, that we inform ourselves about the

* Presented before the House of Delegates Meeting of the Woman's Auxiliary to the Indiana State Medical Association, at Indianapolis, on April 25, 1946.

prepayment medical care plan suggested by our own state, we asked Dr. Walter U. Kennedy, of New Castle, President of the Mutual Medical Insurance, Inc., to talk to the House of Delegates on April twenty-fifth. Such enthusiasm and interest were shown in his message that, with Mrs. Petronella's permission, letters summarizing Doctor Kennedy's talk and containing pertinent facts about the plan of the Mutual Medical Insurance, Inc., were sent to the state officers, state board, and county presidents, to be read and discussed at the May meeting with the purpose of informing the auxiliary so that they might inform their husbands of the urgency, importance, and facts of the plan.

ORGANIZATION

Mrs. F. M. Gastineau

Letters urging organization were sent to the unorganized counties of the state. Several counties replied favorably, but felt that they could not organize at the time because of unsettled conditions due to the war. Wells County has been organized within the past year with fourteen members, and Fulton County is in the process of organization. It is hoped that the coming year will bring more success to the organization chairman of each district.

HYGEIA

Mrs. Otto H. Bakemeier

The Woman's Auxiliary to the Indiana State Medical Association has made a better showing with *Hygeia* this year than ever before in history, with a 165 per cent increase. Four counties made their quotas and four counties were mentioned in the national report as having gone over their quotas. Indiana exceeded its quota by forty subscriptions. To the county *Hygeia* chairman and members, the state *Hygeia* chairman wishes to express her sincere appreciation and thanks for their splendid cooperation.

LEGISLATION

Mrs. F. B. Wishard

The House of Delegates of the American Medical Association passed a resolution outlining work for the Woman's Auxiliary to the Indiana State Medical Association. The most urgent need at the present time is the dissemination of knowledge concerning the hazards of current medical legislation. Each county was asked to participate in the education of its own membership. Literature was distributed promptly, and members were urged to read each issue of THE JOURNAL of the Indiana State Medical Association and *The Journal of the American Medical Association*.

When it was learned that the National Y.W.C.A. was going to support the Wagner-Murray-Dingell Bill at its convention, all of our auxiliary members were alerted in an effort to influence the Y.W.C.A. delegates in their respective communities by proper information.

Speakers have been provided by the auxiliary for various lay groups throughout the year in several counties. Forums and discussion groups have been led by auxiliary members.

ARCHIVES

Mrs. W. R. Morrison

At the board meeting last fall it was voted that the chairman of Archives include in the scrap book only articles having to do with the state officers and auxiliary. As scrap books have not been available, I have arranged such material in the first pages of the larger book. I think it would be a good idea to get publicity on every president since organization, and devote two or three pages to each term of office. I would like to suggest that the local auxiliaries send in articles where state officers have attended meetings.

BULLETIN

Mrs. Ernest O. Nay

The Bulletin is your auxiliary publication. It contains many excellent addresses and much information concerning the plans of the national program, and should be read by every member of the state auxiliary.

The total number of subscriptions from Indiana is ninety, which is twenty-six subscriptions over the total of last year.

PROGRAM

Mrs. E. N. Mendenhall

It is the duty of the program chairman to interpret activities of the various committees of the organization into subjects which may be studied by county units at their meetings or presented to the public in various communities. With this obligation in mind, each state chairman was asked for the projects she wished to emphasize during the year.

The Indiana program was compiled under the four classified classifications—Public Relations, Legislation, Education, and Social—that have been used in Indiana during the last seven years. This compilation was approved by the Advisory Board, the state president and the national program chairman, and was printed and mailed to each county president in August.

Cards were mailed to each county president in March, asking for statistical information. Seventeen counties made reports as follows:

Eighteen public relations meetings and a radio series; eighteen legislative; thirty-four educational; fifty social, and thirty-four meetings combining social hour with one of the other classifications.

This year indicates definite growth in the realization of auxiliary work.

PUBLIC RELATIONS REPORT

Mrs. J. W. Mather

There seems to be among the auxiliaries a keen appreciation of the need for close touch with the community and state in furthering better health standards and better understanding of medical problems.

Some auxiliaries felt that they were too small to undertake any projects. To these I wish to say that one of the aims of the auxiliary is to promote fellowship among doctor's families, and if they do that they are well worth while. As they grow older in association they may undertake more.

One of the best reports comes from Allen County. I expect their president will give a more detailed report, but I should like to repeat some of their accomplishments. They could well serve as an example for our national chairman to hold before other auxiliaries. Among their accomplishments are: four health films from the Indiana Board of Health shown to the public in the city parks; an interesting health program for teen age girls, consisting of eight lessons. These were given in a room furnished by the auxiliary to resemble a powder room; one member also conducted dancing lessons every two weeks; in the city recreation center nutrition classes were taught; the Ideals of American Medicine were presented in an "Information Please" program; and Dr. Morris Fishbein talked on "Present Trends in Medical Legislation Affecting Medicine" at a luncheon which several hundred women attended, among them leaders of civic and national organizations.

Other counties which have done commendably are:

Carroll County Auxiliary urged a new school building project, and more sanitary conditions. They put on a special program on Youth Conservation as a county project in federated clubs. They sponsored programs in other clubs on medical legislation and asked all federated clubs to give to the Cancer Fund.

Vanderburg County Auxiliary put on health programs in the public schools and also had Dr. Buehler talk on Child Psychology. They had programs to promote the Ideals of American Medicine and discussions on medical legislation. An open lecture for the public was given by Dr. Luella Nadelhoffer, who spoke on Cancer Clinics in Chicago.

ANNUAL MEETING
INDIANA STATE
MEDICAL ASSOCIATION
INDIANAPOLIS
OCTOBER 29, 30 AND 31

ANNUAL REPORTS FROM COUNTY AUXILIARIES

ALLEN COUNTY

Mrs. A. C. Worley, President

The Allen County Medical Auxiliary has a membership of one hundred twenty-three. We have held eight meetings during the year, four of which were social, one social and business, one legislative, and two educational.

Public Relations Department:

1. Took charge of a War Bond Booth in June.

2. During Victory Bond Drive in winter canvassed every office and store in a business block.

3. Sixteen members helped sort clothing for Old Clothing Drive for Europe.

4. Juvenile project on health education for teen age girls. This health education project is carried out at the City Recreation Center, at the Jefferson School. We have worked toward this project for two years. After much delay and many difficulties we had the Powder Room furnished well enough to begin our first health lesson on March 25. A series of eight lessons are given, one lesson each week for eight weeks. One of our members has conducted a lesson in social dancing once every two weeks all this winter. We furnished the linoleum, draperies, mirrors, and sanitary covers for the toilet seat. The entire cost to us was $182.13.

During the past summer four health films were procured from the Indiana State Board of Health and were shown to the public in the city parks.

Legislative Department:

1. Meeting on medical legislation at which Dr. Morris Fishbein spoke on "Present Trends in Medical Legislation Affecting Medicine." One hundred seventy-eight members and guests heard this lecture.

2. One hundred seventy-five Dorothy Thompson articles and pamphlets containing editorials from *The Journal of the American Medical Association* were sent to the following: ministers, presidents of Parent-Teacher associations, presidents of Child-Study clubs, Y.W.C.A. board members and employees before Y.W.C.A. conference, presidents of federated clubs, and social workers.

Response from P.T.A. groups tell of meetings they held on socialized medicine, stimulated by this literature.

Health and Education Program:

Forty-seven *Hygeia* subscriptions (45 one-year) (2 three-year). Ten of these were gift subscriptions by the auxiliary to the following:

Y.W.C.A. (1).
Salvation Army (1).
Neighborhood Center (1).
Girls' Juvenile Home (1).
Jefferson Center (2).
St. Joseph's Lutheran and Methodist Nurses' Home (3).
Seven *Bulletin* subscriptions.

CARROLL COUNTY

Mrs. Charles L. Wise, President

The Carroll County Medical Auxiliary has seven active members. Three have just returned from service.

We have had nine meetings with the doctors.

Each member is doing active work on programs for other clubs. Many hours are spent doing Red Cross work. We have five subscriptions to *Hygeia.*

With the increased membership we have at last been able to have an election, and are proud to introduce Mrs. Max Adams as our new president. We anticipate a very progressive year.

CASS COUNTY

Mrs. Charles L. Viney, President

The Cass County Auxiliary has twenty-six paid members, and forty-five *Hygeia* subscription points.

April—Dinner meeting with husbands. A check for $500.00 was sent to the Cancer Control Fund, doubling our quota.

May—A tea was given for the ladies attending the district meeting with their husbands, at the home of Mrs. Bradfield. We were honored by the presence of the state president, who gave a very excellent, instructive, and interesting talk. She also commended the society on the gift toward cancer control and the *Hygeia* subscription rating.

September—Combined dinner with husbands, election of officers, and term set to begin with the state year. Report given of the spring meeting of the House of Delegates of the Woman's Auxiliary to the Indiana State Medical Association.

October—District meeting at Delphi. No county meeting.

November—Combined dinner with husbands. Dr. Jewell gave a report on the meeting of the House of Delegates at the state meeting at French Lick. Dr. Carl Martz gave an address on rehabilitation. A lively discussion followed.

December—Christmas dinner with husbands. An enlightening discussion on "Socialized Medicine" was given by Mrs. Viney.

January—Dinner with husbands. A new membership committee was appointed. A general discussion for plans for future meetings was held.

February—Dinner. Plans were made to have the secretary of the men's organization send cards concerning future meetings to the home instead of the office, in order that the wives would be reminded of the meeting date.

The president gave a very thorough review of the legislative bills from the Council on Medical and Public Relations from the news letters. A spicy discussion followed, bringing more explanations from the president.

Organization voted to take a subscription of the *Bulletin* for the president each year. *Hygeia* reported forty-five points, an increase of 12 per cent points over last year. Every dentist and physician were contacted in the county during the drive, as well as others.

March—Combined dinner meeting with husbands. Mrs. Viney presented a petition sent to our organization by the Indiana State Medical Association concerning the Y.W.C.A. delegates and their voting on the Wagner-Murray-Dingell Bill. All members signed the protest. Plans were completed for the Cancer Control Drive. We were guests of our husbands to hear Dr. Montgomery speak on "R.H.2."

CLARK COUNTY

Mrs. J. T. Carney, President

The following activities are reported for the Clark County Auxiliary:

Sewing and mending for Clark County Memorial Hospital.

Decorating of one room at local U.S.O. Building.

Assisting one day per month at Tuberculosis Clinic.

Picnic for sixteen service men.

Lecture by Lieutenant-Colonel J. Duffy Hancock, chief of Surgical Staff of 106 u/1 Evacuation Hospital.

One luncheon meeting.

Donation of mirror for nurses' home.

Six business meetings and four social meetings.

DELAWARE-BLACKFORD COUNTY

Mrs. A. G. Rettig, President

Meetings of the Woman's Auxiliary to the Delaware-Blackford Medical Society during the year 1945-1946 were well attended.

On May 15, 1945, a dinner meeting was held at the home of Mrs. J. C. Silvers.

In October a dinner meeting was held at which Dr. G. S. Young gave a talk on his travels in the China-Burma-India Theatre.

In January the wives of physicians who had been in service were guests of the auxiliary at a luncheon.

In March a tea was given for the same group, which included wives of resident physicians and interns at the Ball Memorial Hospital.

Beginning with the fall meeting, the aim of our organization this year has been to welcome back and to try to interest again wives of our doctors who have been in the armed services.

Forty paid memberships for 1945.

One subscription to *Hygeia.*

ELKHART COUNTY

Mrs. W. A. Stauffer, President

The Elkhart County Auxiliary has a paid membership of thirty-three members.

We had eight meetings this year, with an average attendance of twenty. One meeting (a potluck) was held in Nappanee, one in Goshen, and the other six in Elkhart.

As our meetings are held the same night as the husbands' meetings we have a dinner and then go to one of the homes for our meeting and program.

We gave ten dollars to each of the following organizations: Red Cross, Cancer Control, and Crippled Children. We have helped in local affairs as much as possible.

FLOYD COUNTY

Mrs. A. M. Baker, President

We have thirty-four members.

We held one meeting each on legislation, health education, social meeting with doctors, library work, juvenile delinquency, and socialized medicine. At one meeting we had a talk by a nurse who had been a Japanese prisoner of war.

We gave financial aid to the Red Cross. All members have given many hours of service.

We had twenty *Hygeia* subscriptions, giving a subscription to the schools. We had fifteen *Bulletin* subscriptions.

HANCOCK COUNTY

Mrs. Charles M. Gibbs, President

The Hancock County Auxiliary now has twelve paid memberships.

Our auxiliary is taking *The Bulletin*—one subscription.

Four Hygeia subscriptions—five renewals.

Two meetings were held and two others are planned. Our project is the hope of helping in a few county hospitals. We have met with the doctors this winter, and had the privilege of having Dr. Ferrell keep us informed about activities of the association.

HOWARD COUNTY

Mrs. R. P. Schuler, President

The Auxiliary to the Howard County Medical Society is comprised of thirty-four active members and associate members.

During 1945 and 1946 we held seven meetings. Federal legislation and proposed federal legislation as well as our Indiana's own voluntary health insurance plan were reported and discussed at three meetings. "The Rise of Anesthesia" was reviewed by one of our members for the program of another meeting. *Bulletin* and *Hygeia* chairmen gave resumés of interesting articles for one meeting. The state president, Mrs. Grank Gastineau, was our guest in January.

Our public relations chairman, in cooperation with the Bureau of Publicity of the Indiana State Medical Association, has arranged for five broadcasts with our local radio station on the following topics:

1. The National Program.
2 and 3. The Indiana Prepayment Medical Care plan.
4. The Blue Cross Plan.
5. Summary.

The chairman of *Hygeia* reported nine subscriptions.

LAKE COUNTY

Mrs. Milton B. Gevirtz, President

The Lake County Auxiliary held five general meetings.

Hygeia subscriptions, 49.

Bulletin subscriptions, 16.

June—Spring luncheon and book review.

October—Open meeting held in Chicago, with Mrs. Mary Powers, head of the Chicago Detention Bureau, as guest speaker.

December—"Oberlin Award" dinner.

March—Our meeting was held in East Chicago, with Robert Yoho, of Indianapolis, director of the Indiana State Board of Health, as speaker.

April—A scholarship fund in honor of Mrs. Adelaide Shanklin was established for the training of Lake County Nurses. It was decided to make it perpetual, rotating yearly between Gary, Hammond, and East Chicago.

Members spent many hours making surgical dressings for the Red Cross; worked on the Cancer Control drive, tag day, and as Grey Ladies.

MADISON COUNTY

Mrs. Florence W. Smith, President

The Madison County Medical Auxiliary held seven meetings, with an average attendance of twenty-five members. We have forty-eight paid-up members.

The December meeting was a Christmas party held in the spacious home of Mrs. Rex Dixon. Following a brief business session there was a gift exchange and bridge was played. At our March meeting we were honored in having as our guest our state president, Mrs. Frank M. Gastineau, who gave an informative talk on "Socialized Medicine." Most of the meetings have been social. A number of our members have been devoting at least two afternoons a month to making surgical dressings and informing church and social groups on socialized medicine.

MARION COUNTY

Mrs. Matthew Winters, President

The Woman's Auxiliary to the Marion County Medical Society had the following meetings this year:

December—A luncheon-bridge at the Propylaeum, with the membership and hospitality committee in charge.

January—A legislative meeting and tea at the St. Vincent's Hospital Nurses' Home. The speaker was Dr. LeRoy Burney, the new Commissioner for the Indiana State Board of Health. The Legislative Committee was assisted by the Social Committee.

March—Our Public Relations meeting and tea was held in the L. S. Ayres and Company auditorium. Dr. LeRoy Burney was asked to speak at this meeting, also, because the committee felt that

he had pertinent and interesting information to give concerning the needs, responsibilities, and services available to the public through the State Board of Health. Invitations were sent to various community and civic organizations. A representative group of about one hundred fifty persons attended the meeting. The War Service Committee assisted.

May—Luncheon and bridge at the Meridian Hills Country Club. Annual reports were given and election of officers was held at this meeting. The program committee was in charge, assisted by the *Hygeia* and *Bulletin* committees.

Letters were sent to each of the fifteen delegates from Indianapolis to the national meeting of the Y.W.C.A., asking their careful consideration of the proposed endorsement of the Wagner-Murray-Dingell Bill by their organization.

At the request of the medical society, a large committee solicited all the doctors for the Red Cross Drive.

Our membership is now 218, an increase of 37 members over 181 last year.

The *Hygeia* subscriptions were 159, an increase of 64.

We had 10 subscriptions to *The Bulletin*.

We lost one member by death—Mrs. William Niles Wishard, Sr.

MARSHALL COUNTY

Mrs. M. O. Klingler, President

The Marshall County Auxiliary reports as follows:

Paid-up members, 6.

Bulletin subscriptions, 6.

Hygeia subscriptions, 0.

Meetings, 7: social 1; educational 3; legislative 2, and public relations 1.

NORTHEASTERN ACADEMY OF MEDICINE

Mrs. Marie B. Fipp, President

The Northeastern Academy of Medicine was organized on February 29, 1940.

Soon after the outbreak of the war the academy voted to suspend its meetings for the duration, which also curtailed the activity of the auxiliary. We are just now getting under way, and have held three meetings during the year, but all since December. Our membership has risen from seventeen to twenty-four, with four additional members whose dues came too late to be counted. We are making a drive to enlist the interest of those who are not already enrolled as members.

These meetings have been social in character, with an informal discussion of legislation and policies affecting the status of medicine. The work accomplished has been done as individuals rather than as a society, due to the inactive status of the organization. But as individuals the auxiliary has been well represented in the various phases of war work and community projects. And, above all, the members have taken the responsibility in seeing that they were accurate sources of information about the various aspects of "Socialized Medicine." We also participated by sending petitions to our congressmen as urged, and we are "standing by" for anything we can do for the welfare of the auxiliary. Our Academy of Medicine is very favorably disposed, I may add.

PORTER COUNTY

Mrs. E. J. VanWinkle, President

The Woman's Auxiliary to the Porter County Medical Society was organized on May 8, 1940, and has met regularly to date. There are twelve paid memberships and the prospect of two new members, who are doctors' wives living in the town of Chesterton, twelve miles from Valparaiso. Our auxiliary subscribes to two *Bulletins* and has sold twenty-one *Hygeia* subscriptions in the past year.

Our meetings are held at the homes of members and usually consist of a carry-in-dinner, a business meeting, and a program to deal principally with subjects relating to the medical field, such as excerpts from *Medical Economics*, *The Bulletin*, or reports concerning latest developments of the various medical bills pending in Congress.

At one meeting Miss Dorothy Smith, our school nurse, presented an unusual account of her experiences overseas. She explained the plight of the French and German civilians and of the medical attention they are receiving at present.

The only social meeting enjoyed by the group was the book review given by Virginia Kendall Upham on the "White Town," at the University Auditorium.

ST. JOSEPH COUNTY

Mrs. D. A. Bickel, President

The St. Joseph County Auxiliary reports as follows:

Number of members, 110.

Service wives, 41.

Hygeia subscriptions, 99.

Bulletin subscriptions, 3.

Meet six times yearly—average attendance, 40.

Activities: Primarily social; promotion of *Hygeia;* study of legislation.

Have provided *Hygeia* to all schools, and placed twenty-five free subscriptions in other public places.

VANDERBURGH COUNTY

Mrs. William Healy, President

Our auxiliary has a membership of 87 members, an increase of 10 over last year. As a group they are active workers and are represented in practically every organization in the city. For example, we had ten members working in the Red Cross Home Service Department giving approximately 4,034 hours of service. We were also represented in Junior Red Cross, surgical dressing and home

(Continued on Page xxx.)

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(Continued from Page 384.)

nursing departments, giving another 447 hours of service. We had numerous members working on the Red Cross Fund Drive, giving 157 hours. Our president-elect acted as chairman of the Woman's Division of the Red Cross Drive, while we had other members serving as majors and captains. We are proud to say that through their efforts it helped the residential division to reach its quota.

Our members also were active workers for the Community Fund and Museum Fund drives. We also assisted with the sale of Christmas Seals. We had members working daily at the Red Cross Canteen and at the U.S.O., giving 453 hours of service. Our members are active in Parent-Teachers work, serving on health committees and one as president of the P.T.A. The auxiliary has active representation in the following organizations, most of which are in an official capacity: Brownies, Girl Scouts, Cub Boy Scouts, American Association of University Women, Junior Service League, and the League of Women Voters.

Our programs throughout the year were various. We visited the Woodmere State Hospital; had our state president, Mrs. Frank Gastineau, as guest and speaker; membership holiday tea; program by Dr. Elmer Weber, Health and Physical Education Director of the City Schools; dinner-dance; and a lecture by Dr. Francis Buller, of Evansville, on "Child Psychology."

The auxiliary responded to the Cancer Control Drive by bringing to Evansville from the Cancer Prevention Clinic in Chicago, Dr. Luella Nadelhoffer, thus helping the people of Evansville for the first time to realize the need of a cancer prevention clinic.

One of our foremost thoughts is to uphold the resolution passed by the American Medical Association with reference to the Wagner-Murray-Dingell Bill.

Vanderburgh County was one of the four counties in the state to reach its quota in the *Hygeia* contest. Last year we were at the bottom of the list, and are happy to report 87 9/12 subscription credits. We have 5 subscriptions to *The Bulletin.*

I am happy to say that the members of the Woman's Auxiliary to the Vanderburgh County Medical Society are active and cooperative workers which laid the foundation for a year's work well done.

VIGO COUNTY

Mrs. C. R. LaBier, President

The Auxiliary to the Vigo County Medical Society had a membership of sixty-one during 1945-46. There were six well-attended meetings. Three of these were luncheon meetings, one an evening dinner, a tea, and a public relations meeting. Perhaps the outstanding meeting was our November luncheon, at which time we were privileged to entertain our state president, Mrs. Frank Gastineau, and the state parliamentarian, Mrs. Charles Voyles. Our program was an excellent panel discussion on state medicine, given by four of our members. In April a public meeting was held at one of the hospitals, where a program was presented by the Public Health Nursing Association.

In the field of public relations, the auxiliary gave eight hours to the sale of Christmas Seals, and assisted in the Red Cross Drive. We sent literature to the Terre Haute Y.W.C.A. representative at the Atlantic City convention on the case against state medicine.

Seventy-seven subscriptions to *Hygeia* were obtained. The Vigo County Medical Society gave the auxiliary $25.00 in money for *Hygeia,* and this was used in placing *Hygeia* in such public places as the Y.W.C.A., the Y.M.C.A., the library, several beauty shops, the Toner Settlement House, both Hospitals, the Public Health Nursing Association, a club for colored young people, the U.S.O. lounges, and the schools.

The auxiliary continued its occupational therapy program, working in cooperation with a men's service club. Occupational therapy was made available in both hospitals, as well as in the outpatient workroom maintained for the benefit of crippled and handicapped children. Two thousand eight hundred and five patients were helped by this program during the year.

The fiscal year was changed to start in the spring, rather than in the fall, in order to conform to the program of the state auxiliary.

WELLS COUNTY

Mrs. Truman Caylor, President

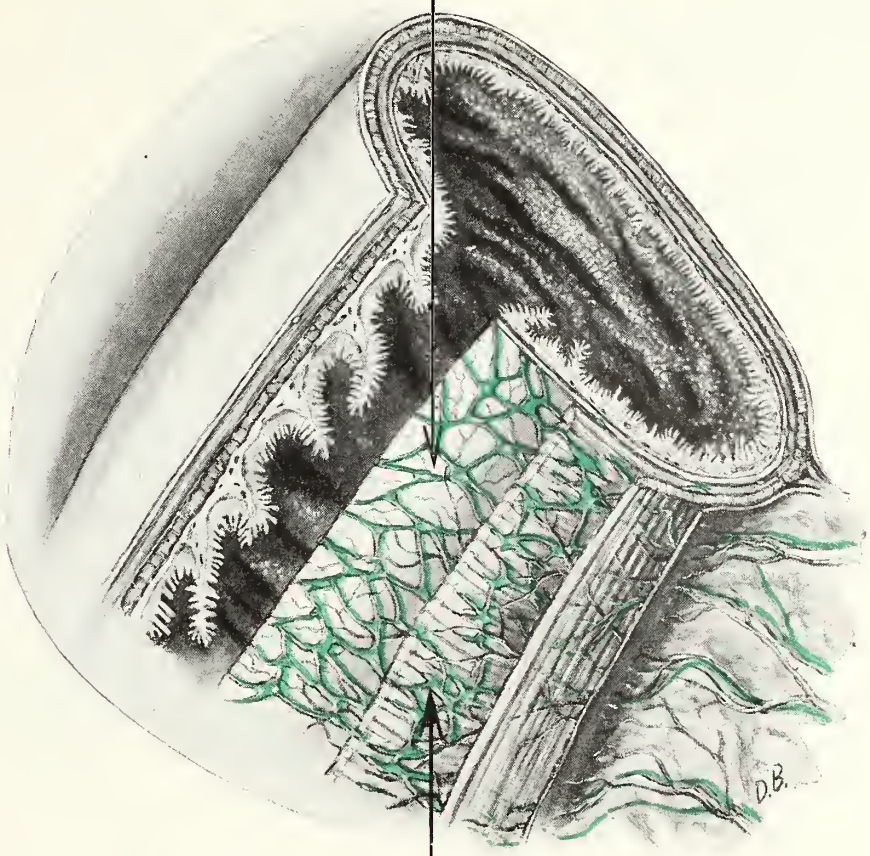
This report follows as nearly as possible the suggested outline given in the *Handbook* for the state auxiliaries.

There are twenty-one doctors' wives in Wells County eligible for membership. We have fifteen members at the present time. This auxiliary was organized on May 5, 1945.

Our programs have varied considerably. Miss Williams, our public health nurse, spoke to us on her duties in Wells County. We have had several educational and legislative programs prepared by our own members, from material gleaned in most part from *Hygeia, The Journal of the American Medical Association,* our *Bulletin,* and the *Parents Magazine.*

Several of our members have been active in helping with the various health drives, such as Infantile Paralysis, Cancer, and the one for Crippled Children.

Our *Hygeia* subscriptions totaled eleven. We gave *Hygeia* subscriptions to our Parent-Teacher presidents at Bluffton. Seven of our members are



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Bulletin subscribers, and we hope to raise these figures next year.

All our meetings are planned to create and encourage friendliness. We meet on the same evening as the Wells County Medical Society, and after their meeting is over the husbands join us in a bit to eat and a bit of fun before adjourning.

LOCAL AUXILIARY REPORTS

CLARK COUNTY

The regular monthly meeting of the Woman's Auxiliary to the Clark County Medical Society was held Friday at the home of Mrs. E. P. Buckley, at Jeffersonville.

Officers elected at the meeting for the ensuing year were Mrs. Sam Adair, President; Mrs. Mier Bizer, Secretary; Mrs. O. P. Graham, Treasurer; Mrs. J. T. Carney, Corresponding Secretary; Mrs. C. F. C. Hancock, Publicity Chairman; Mrs. Lee Dare, *Hygeia* Chairman.

A report of the annual meeting of the Auxiliary held at Indianapolis on April twenty-fourth was given by Mrs. J. T. Carney and Mrs. Sam Adair.

ST. JOSEPH COUNTY

The Woman's Auxiliary to the St. Joseph County Medical Society was entertained Friday afternoon in the home of Mrs. F. W. Logan. The assisting hostesses, all of Mishawaka, were Mrs. C. J. Goethals, Mrs. Richard Ganser, Mrs. James W. Ward and Mrs. R. J. Zimmer.

The program was a panel discussion of "Pending Medical Legislation," presented by Mrs. Kenneth L. Olson, Mrs. Raymond Nelson and Mrs. K. E. Selby. The annual tea and final meeting was held on May twenty-fourth at the home of Mrs. C. Allan Bishop.

ABSTRACT

FRENCH HEALTH UNDERMINED UNDER NAZI RULE

A picture of public health conditions in France during the four years between the invasion and the liberation is painted by a prominent Paris physician in the current issue of *War Medicine*, published by the American Medical Association. He is L. Justin Besancon, professor at the Faculté de Medicine, Paris; physician of Paris hospitals, and president of the French Red Cross.

Touching on the appalling shortage of drugs, Dr. Besancon said that "the day Paris was liberated there was only a fifteen-day supply of ether that might be used as an anesthetic in hospitals," and then added: "I cannot speak of the supply of penicillin because all that was known of this marvelous new drug was what had been heard on the radio.

"The situation was tragic so far as insulin was concerned. A severe rationing of available supplies brought the monthly consumption down to 10,000,000 units for 13,000 persons with diabetes. At the time of liberation, France's insulin reserves were practically exhausted."

Dr. Besancon cited six major causes which undermined the French public health: hunger, fatigue, acts of war, deportation, contagion, and lack of body hygiene.

"Famine began right after the invasion," he said. "The Germans had developed a technique so fine that as early as the last two months of 1940 the first cases of starvation edema were observed in one of the insane asylums. From 1941 on, food supplies were notably deficient for the entire population. It is common knowledge that the optimum supply of food for an adult who does an average day's work—a physician, for instance—is from 2,500 to 3,000 calories. The Vichy feeding varied between 1,000 and 1,500 calories, that is to say, about one-half of the optimum ration and 300 calories less than the vital minimum, which is usually considered as being 1,800 calories.

"Conditions were no better for laborers. Their maximum ration, which should be somewhere between 3,000 and 5,000 calories, was not more than 1,500 calories.

"I might as well say that in any place where people had to eat in accordance with the points system alone, and had no other source of food, starvation existed in its most serious aspect. Especially is this true in the insane asylums where patients were known to die of starvation by the hundreds.

"The average food shortage for the entire population was 23 per cent for school children, 42 per cent for adolescents, 60 per cent for adults, and 55 per cent for the aged.

"Fatigue was another major cause of the debilitation. The need for one to flee from the invading enemy and the need to escape out of the cities he bombed brought about serious repercussions on one's health. Furthermore, for four long years, transportation facilities became less and less available. To this was added the sufferings brought about by cold due to the shortage of fuel. Public buildings as well as private homes were entirely inadequately heated.

"Deportation brought a heavy blow to the French population. Anxiety, worry, and the depression of one's morale on seeing relatives and friends forcibly deported are some of the causes of the recrudescence of affective psychoses.

"Contagion was brought about by the existence of a floating population. This was especially true for the patients with tuberculosis, who had to leave their sana-

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toriums because of lack of food supplies and be sent, haphazardly, into whatever farm area might be available.

"Finally, there was the lack of personal hygiene. Shortage of soap and poor laundry services, especially in the washing of bed sheets, brought about a major-sized epidemic of scabies and cutaneous infections.

"Pediatricians were greatly concerned with the problem of growth in children. Julien Huber's investigation in 1942 showed that the weight of babies at birth was often less than 6.2 pounds. Premature birth occurred frequently. Precocious infantile mortality increased by 100 per cent. Breast feeding became more and more difficult, the mother being decidedly underweight and exhausted.

"In the course of six months, 35 per cent of the girls and 41 per cent of the boys either have lost weight or their weight has remained stationary. In the cases of those who have gained weight, the increase is inferior to the corresponding increase in physiologic growth.

"Institutionalized patients, eating only the controlled and limited amount of food provided by their ration points, were, in a way, the guinea pigs of the German scientists. The French also, to their great sorrow, were able to learn what limited diets could do to human beings. Edema would set in within four to six months.

"Patients living in their own homes, eating a diet which was made up of cabbage, rutabaga, and carrots, with a serious deficiency of calories and elective deficiency of meats and fats, were observed to suffer greatly from hydrops.

"There was an increase in the frequency of pulmonary tuberculosis during the war, and its forms were of the most acute kind. From 1938 to 1941 the mortality due to this disease increased by 30 per cent. From 1941 on, the increase is still about 20 per cent above the pre-war increase. Many of those who had been locked up for any length of time by the Gestapo in concentration camps and in prisons were in a state of complete exhaustion. This state, together with malnutrition, gave rise to the most acute forms of pulmonary tuberculosis."

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—May, 1946

Diseases	*May 1946*	*April 1946*	*March 1946*	*May 1945*	*May 1944*
Tuberculosis, Pulmonary	163	206	262	167	137
Tuberculosis, other forms	6	14	12	10	3
Chickenpox	297	327	529	219	371
Measles	1957	2948	4371	157	576
Scarlet Fever	225	359	517	403	561
Smallpox	14	2	5	10	8
Typhoid Fever	4	7	4	3	9
Whooping Cough	70	106	109	72	46
Diphtheria	36	41	57	17	17
Influenza	21	57	74	26	6
Pneumonia	22	20	35	9	5
Mumps	182	183	191	237	208
Ophthalmia Neonatorum	1	.....	.....	.....	.....
Infectious Jaundice	1	4	4	.....	.....
Cerebro-Spinal Meningitis	10	15	13	12	23
Meningitis, Nonepidemic	1	.....	.....	2	1
Encephalitis, Lethargic	1	.....	.....	.....	.....
Encephalitis, Noninfectious	2	.....	.....	.....	.....
Undulant Fever	8	2	9	3	3
Tularemia	1	1	2	.....	.....
Malaria—Acq. outside U.S.	19	26	53	.....	.....
Malaria—Acq. inside U.S.	1	1	1	1	.....
Septic Sore Throat	23	17	42	1	1
Amebic Dysentery	1	1	.....	.....	.....
Bacillary Dysentery	1	.....	.....	.....	.....
Erysipelas	1	4	2	1	.....
Vincent's Angina	4	.....	.....	2	1
Impetigo	6	2	7	2	2
Conjunctivitis	5	2	1	.....	1
Rubella	28	60	30	8	10
Poliomyelitis	.....	1	3	4	1
Unclassified Dysentery	.....	1	1	2	1
Tetanus	.....	2	.....	2	1
Ringworm of the Scalp	.....	304	12	.....	.....
Trachoma	.....	.....	.....	1	1
Rocky Mt. Spotted Fever	.....	.....	.....	2	.....

ATTENTION, PHYSICIANS!

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There is now a surplus, which is available to any physician for use in his regular practice, at thirty-five cents an ounce. The milk may be obtained by contacting Miss Plaster, Diet Kitchen, Indianapolis City Hospital.

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ANTERIOR POLIOMYELITIS*

ROBERT O. RITTER, M.D.†

CHICAGO

Anterior poliomyelitis is a very ancient disease. Some three thousand years ago the Egyptians pictured in stone what today we would consider typical results of poliomyelitis. Hippocrates described an epidemic paralysis of the legs that "attacked many" in the late summer. But it was not until 1840 that this disease was established as a clinical entity by Heine. During the first forty years only cases with a flaccid paralysis were diagnosed as poliomyelitis. In 1884 Strumpell described what he termed "the cerebral type." He described the acute onset with fever, vomiting, and convulsions, followed by a cerebral type of paralysis. He stated that signs of motor irritation may persist. However, his description more closely describes an acute encephalitis with resulting spastic paralysis.

Others have described the non-paralytic type where the early symptoms subside so quickly that no damage is done to the motor cells. There is also a very mild abortive form of the disease that produces no clinical signs of central nervous system involvement or changes in the spinal fluid. This type can be diagnosed only by elaborate laboratory examinations.

Poliomyelitis is an acute infectious disease caused by a virus about which very little is known. We do know that it attacks, and may completely destroy, the motor cells that control certain muscle groups. Actually, this disease has a relatively low attack-ratio and is much less contagious than most of the common infectious diseases of childhood. Cross-infection in hospitals is rare, and infection of contacts is rare.

It is generally believed that the virus enters the central nervous system from the nasopharynx by way of the olfactory nerve. Some believe that it enters from the digestive tract; however, finding the virus in the digestive tract does not prove that that is the portal of entry. It may have been swallowed with the secretions of the nasopharynx.

The incubation period is from seven to fourteen days. The initial symptoms are the same in all types of the disease, except the abortive, and they may be as severe in the non-paralytic as in the paralytic form. In fact, one cannot predict the extent of the paralysis by the severity or mildness of the early stage.

The onset is, as a rule, very abrupt and the symptoms progress rapidly and uninterruptedly from one stage into another. The early symptoms are those of headache, vomiting, fever, and gastrointestinal disturbance. The fever usually lasts from five to ten days and falls by lysis. The pulse rate is usually in proportion to the fever. A more rapid rate may indicate an early bulbar involvement and a poor prognosis. Hyperesthesia is an early symptom. This may be quite general, and the child may complain of pain at the slightest touch, but it usually is more marked over the large nerve trunks and the back. Pain is an almost constant symptom in the early stage and is present in the neck, back, abdomen, or extremities.

The pain varies in severity. Sedatives or opiates may be necessary to relieve it. The duration of the pain is usually short, but it may last well into the convalescence. Tremors or twitching of muscle groups are sometimes early symptoms. Convulsions are rare. Stiffness of the neck and back are important signs.

Changes in the reflexes are important. Early in

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the disease the deep reflexes are usually exaggerated and equal. There may be a Babinski or ankle clonus at times. As the disease progresses the deep reflexes become more unequal, diminished or lost, especially if paralysis is about to develop. The superficial reflexes are present unless there is a paralysis of the underlying muscles.

There is no known preventive for this disease, but some general precautions may help:

1. Avoid overexertion.
2. Practice cleanliness. The virus lives in sewage and may be carried by flies.
3. Avoid sudden chilling, such as a plunge into cold water on a hot day or after excessive exercise.
4. Avoid tonsil and adenoid operations during epidemics.
5. Be sure that drinking water and milk are clean.
6. Avoid swimming or wading in dirty pools.

Individuals who are attacked by poliomyelitis are never cured; they recover, and what we do for them only assists in their recovery. It is true that some 80 per cent will recover without significant residual paralysis, but there is as yet no means of telling which early cases will be in that group. There is no way of preventing its spread, and there is no known cure.

In the acute, febrile stage which lasts only a few days the treatment is symptomatic. Bed rest in a quiet, darkened room is indicated. Sedatives should be given for restlessness or for pain. Prostigmine and curare have been recommended for relief of muscle spasm and contracture. Convalescent serum in the preparalytic stage may be given if the parents demand it or if the physician wants to give it. Many believe it has no specific value.

The stage of tenderness and early contractures begins after the fever subsides and lasts from three to six weeks or longer. During this stage the affected extremities are kept in neutral position by splints or casts. These may be removed at intervals and passive motion given. Warm baths or hot packs may be used. Massage in this stage may increase pain and contractures, and should not be used.

The convalescent stage begins when all tenderness is gone, and lasts from a few months to a few years. The paralyzed muscles begin to regain their power if there has been no permanent damage to the cells in the anterior horns. Muscle-training, by passive and active motion, and underwater exercises may be used. The patient is allowed to be out of bed, and the affected muscles are protected by splints or braces. Muscle-training is continued until no further improvement is shown.

The chronic stage begins when treatment fails to produce further improvement. In this stage the deformities develop by the stronger muscles overcoming the weaker ones, if not prevented by proper supervision. The Kenny treatment is based on the theory that muscle spasm, muscle incoordination, and mental alienation are the cardinal symptoms. Miss Kenny says that this spasm and pain must be relieved before the persistent muscle spasm causes paralysis or muscle weakness.

The hot packs are of value in the acute stage as relief for pain and spasm. Pieces of a woolen blanket cut in appropriate size and shape are soaked in boiling water, run through a tight wringer twice, applied to the affected parts, and covered with oiled silk. Miss Kenny uses continuous hot packs, passive motion, and one or two active movements twice a day until useful function is restored. She does not permit the use of splints or braces. To avoid any splinting effect, the joints are not included in the packs. No surgery should be done until one is sure all natural improvement is at an end, unless it is some simple procedure such as a tenotomy, to make the wearing of a brace possible.

There are two indications for surgery: first, to correct deformities and prevent their recurrence; second, to allow braces or other apparatus to be discarded. Each must be studied and the surgical procedure for that particular individual carried out. However, certain operations, such as spine fusions and arthrodesis, have become fairly well standardized. Tendon transplantation in selected cases usually gives excellent results. The transplantation of the hamstrings forward to the patella for paralysis of the quadriceps extensor, and the tendon of the peroneus longus down the sheath of a paralyzed anterior tibial are good examples. Transplantation of the peroneus longus tendon down the sheath of the paralyzed anterior tibial will correct a foot drop but not a lateral deviation of the foot. The transplant should always be combined with a triple arthrodesis.

For a flail foot, a pan-arthrodesis, with the foot placed in just enough equinus for weight-bearing on the entire foot when the shoe is on, usually gives a very satisfactory result.

PLAN TO ATTEND SCIENTIFIC SESSIONS, OCTOBER 30, 1946

The scientific sessions at the annual meeting of the Indiana State Medical Association, to be held at the Murat Temple, Indianapolis, on Wednesday, October 30, 1946, promise to be banner meetings, and this year there will be the added feature of the new Section on the General Practice of Medicine.

THE EVOLUTION OF THE TREATMENT OF PILONIDAL CYSTS AND SINUSES

LIEUTENANT COLONEL RANDOLPH L. CLARK, JR., M.C.*

RANDOLPH FIELD, TEXAS

Anderson[1] in 1847, in a report entitled "Hair Extracted from an Ulcer," was apparently the first physician of the modern era to call attention to pilonidal disease. In the almost one-hundred-year interval since his paper was written numerous and often bizarré have been the proposals for eradication of this condition. In the past decade alone eighty-seven publications on this clinical entity are recorded in various medical journals. It is to be hoped that a regimé of therapy that will result in complete cure of pilonidal disease in every instance will be evolved from the tremendous accumulated experience of the surgeons in the armed forces during the present war. Not only must the ideal procedure cure the lesion, but it must accomplish this objective with a minimum of morbidity. It is the purpose of this paper to present for your consideration a proposed regimé which, in the opinion of the author, answers the above rigid requirements. The best method of presenting the details of the proposed treatment will be by an account of its development.

FREQUENCY OF OCCURRENCE

Before the present war individual surgeons rather infrequently performed operations designed to remedy pilonidal cysts and sinuses. Impressive series of operated patients with this malady were usually accumulated at large institutions only, and even here the operations were frequently performed by a number of surgeons. This is well illustrated by one of the larger series of cases appearing in the literature and reported by Kooistra.[2] During a fourteen-year experience at the University Hospital at Ann Arbor, Michigan, covering 313,285 admissions, a diagnosis of pilonidal sinus was made in 350 instances; an incidence of 1:940. Thirty per cent of these patients were college students. From another institution which had an admission public more representative of the actual age distribution encountered in civilian life there were 336 patients afflicted with pilonidal disease in slightly over 700,000 admissions, covering a ten-year period. This was an incidence rate of 1:2100. The patient age with the greatest frequency of occurrence was twenty-five years in the first series and thirty-one years in the second series. In other words, the greater the percentage of hospital patients in early adulthood that are included in any series of admissions, the greater will be the incidence of pilonidal disease. This is in a large measure the reason for the high percentage of occurrence of this malady among soldier patients; that is, we have a concentration of men in the proper age group for this disease and who are known to have pilonidal cysts four times as frequently as women even in civilian life. In the first two years of the war more soldier days were lost to the Army because of pilonidal disease than for the treatment of any other remedial defect. As a consequence many surgeons in the armed forces have had a much greater individual experince in caring for this condition than has ever before been accumulated by one group. The chiefs of surgery of twenty-five of the Air Force regional hospitals have been interviewed in the past two months, and it was found that the number of individual operations performed on the service of each of the group was between 200 and 453 for the eradication of pilonidal cysts. In no instance did this report extend over more than a three-year period. From this tremendous experience many interesting facts concerning treatment have been evolved.

EVOLUTION OF CLOSED OPERATION

The preponderance of civilian experience [3 4 5 6 7 8 9 10 11 12 13] at the time of the opening of the war dictated that an excision of the cyst be made and followed by packing the wound open until it healed secondarily. The author's experience with pilonidal cysts at the time of admission to the Army included a modest series of operated cases and a detailed review of 336 patients operated by sixteen surgeons. One hundred forty-eight of these operations were performed by the "open" technique with subsequent healing in every instance. The remaining

* Chief, Department of Surgery, A.A.F. School of Aviation Medicine, Randolph Field, Texas.

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[2] Kooistra, H. P.: Review of Literature and Report of Three Hundred Fifty Cases, *Am. J. Surg.*, **55**:3-77, 1942.

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188 patients were operated upon and the wound closed at the time of surgery with primary healing in 73 per cent of them. The safest method to pursue in obtaining final assured healing following excision of pilonidal cysts and sinuses appeared to be by not attempting primary closure. In the Army, however, it soon appeared that we had not reckoned on the number of man days lost as a result of a slow-healing open wound at the base of the spine. The soldier's life is incompatible with partial disability, so it was necessary for him to remain in the hospital until complete healing had occurred, a period averaging about forty-five days, with twenty-six days the minimum and one hundred ten days the maximum. If the time element of recovery was to be speeded up it was evident that a partial to complete closure of the wound was a desirable objective. Procedures using both partial and complete closure were tried on our service at one of the large Army Air Force Hospitals. Approximately one hundred fifty operations were performed before the present techinque for treatment was fully developed.

There are four general classes in which may be grouped all operations for the cure of pilonidal disease (Figure I):

The first type is the "open operation" performed by excision of the cyst, followed by packing the wound open and allowing it to heal secondarily.

The second type is the "partial closure" group and is characterized by the incomplete approximation of the tissues of the wound, with no attempt being made to close the skin. The object of such an operation is to reduce the amount of dead space ordinarily left to heal when the open operation is used, and by permitting drainage it is hoped to avoid the secondary breakdown of the wound frequently encountered when complete closures are attempted. The method of partial closure is generally achieved by passing heavy stay sutures through the side walls of the incision to the sacral fascia of the opposite side. Numerous devices, such as figure-eight stitches, on-end mattress sutures, the use of buttons, rubber tube, or gauze bolsters to tie the stitches over have all been tried. Another type of "partial closure" is obtained by suturing the skin margins to the sacral fascia after the technique of McFee.[14] The "partial closure" operation, in our hands, has left much to be desired with stitch infection, pressure necrosis of the skin, combined with the inherent defects of the procedure, resulting in a healing time far too long in the majority of patients. However, approximately 40 per cent of our patients' postoperative wounds healed without having to be reopened.

The third type of operative procedure is "complete closure with tension" on the wound. There are numerous variations in this operation, but the simplest form utilizes deep-placed tension sutures to close the depths of the incision combined with skin approximation by superficial sutures. An example of this type of operation is that proposed by Colp.[15] A drain may or may not be used. Other operations of this category call for formation of flaps of skin, fat, fascia, or muscle to attempt to close the dead space left by excision of the cyst.

On our service this type of operation resulted in primary healing in approximately 60 to 65 per cent of the patients submitted to surgery. Our results were better than when the partial-closure procedure was used, but were far from our goal of primary, complete healing for every operated patient. Therefore, this technique was abandoned in favor of the last class of surgical procedure.

The fourth type of operation[16,17] is achieved by carefully performed surgery, requiring no more finesse than that proposed by Halsted for use in doing any surgical procedure. There has apparently persisted a general reluctance on the part of most general surgeons to apply these niceties of technique to the surgery performed on the anal and gluteal regions. It is often a pleasant surprise to find that these areas respond very well to kind treatment.

The operation is in reality simply an excision of the diseased tissue, followed by a complete closure of the wound without tension, and may be termed the "plastic operation" for pilondial cyst. Very definite features are incorporated in the plan to attain primary healing. No operation other than drainage is performed on patients with actively infected lesions. Careful pre- and post-operative attention is directed to the elimination of secondary wound infection. An elliptical incision is made, saving all possible skin but at the same time removing all diseased tissue. Moderate undercutting of the wound edge is carried out when needed to facilitate tensionless closure. Ischemia or necrosis of segments of tissue is avoided by eliminating the heavy stay sutures which are also not considered desirable because of the likelihood of the formation of a pathway for the admission of infection. Only fine cotton, silk, or plain catgut are used in the depths of the wound to avoid any unnecessary reaction. Absolute hemostasis is necessary to prevent hematomas or collections of pockets of serum. The use of the sulfonamide drugs in the wound has been abandoned as it unquestionably produced a "wet" incision. The skin edges are very carefully approximated with fine silk to avoid even the smallest openings. A dressing exerting even moderate pressure is considered desirable, and for this purpose mechanic's waste is utilized. If the thick dressing is used in a hot, damp climate the skin has a tendency to become macerated, and in

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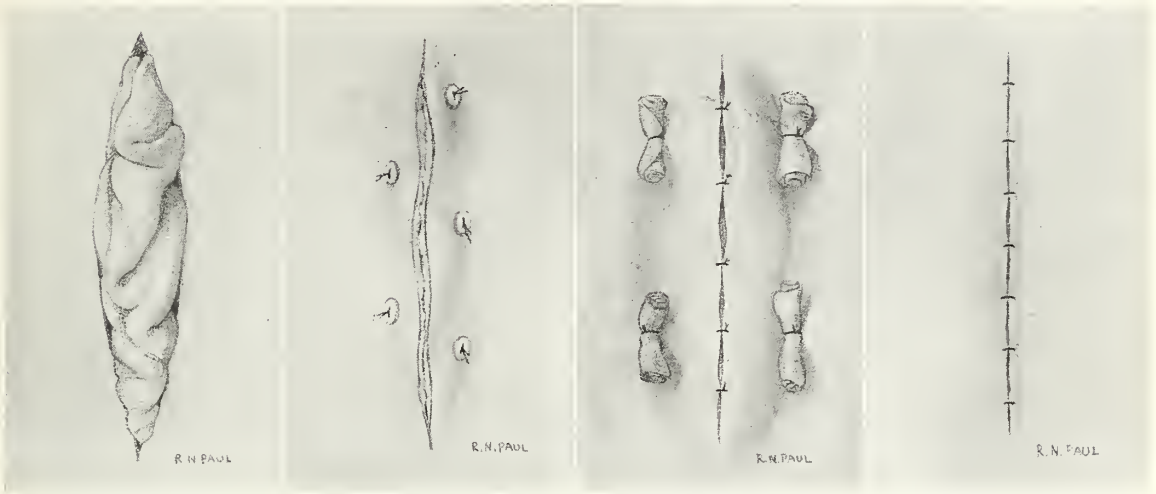
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FIGURE I.

The Four General Types of Operations for Pilonidal Disease



1. Open Operation. *2. Partial Closure.* *3. Complete Closure with Tension.* *4. The "Plastic Operation" or Complete Closure with Tension.*

a few instances there may occur a low-grade infection of the hair follicles. Following the suggestion of Dr. B. B. Larsen it has been found that this does not occur when sulfanilamide powder is placed on the external surface of the skin surrounding the wound.

With the so-called "plastic repair" our results for the treatment of pilonidal cysts were much improved, and as high as 75 per cent primary closures were obtained. A study of our failures with the use of the "plastic operation" revealed four reasons for not securing primary healing. These were:

1. Incomplete excision of the diseased tissue.
2. Infection.
3. Hematoma.
4. Improper closure.

By improper closure it is inferred that either too much tension was required to close the incision or the dead space in the wound was not eliminated. In any instance where one of these four factors were present, healing could occur only by the process of granulation tissue formation. If the wound did not completely break down, the overlying skin would frequently heal, leaving a sinus just over the sacral fascia. This sinus would usually form at the lower end of the incision and pass cephalad under the bridged overskin. If only a small pocket of granulation tissue formed in the depths of the wound, as long as six months have been known to pass before an outside opening was attained. These patients were not suffering from recurrence of the original lesion, but from incomplete healing following the initial excision.

The first two factors responsible for failure to heal can be definitely eliminated by careful surgery performed at the correct time. Because of the site of the lesion the last two factors are more difficult to deal with. Undercutting the wound edges to relieve tension and thus allow closure of the dead space involves opening across many small vessels and increases the likelihood of hematoma formation. Fat grows to fascia with reluctance, especially when blood or serum accumulates between the two. Therefore, some substance that would increase hemostasis and at the same time attach fat to fascia until healing had occurred would be the answer to our remaining problem. Accordingly, in the latter part of 1943 various substances that might bring about this desired result were tried, at first without success. One of the procedures attempted was the clotting of plasma in the wound. This was suggested by the report of J. Z. Young and P. B. Medawar, [18 19 20 21 22 23 24 25] who were using cockerel plasma and rabbit globulin for the suture of nerves. Other reports, [18 19 20 21 22 23 24 25 26 27] of the use of plasma or plasma fractions for nerve and

[18] Young, J. Z., and Medawar, P. B.: Fibrin Suture of Peripheral Nerves, *Lancet*, **2**:126, 1940.

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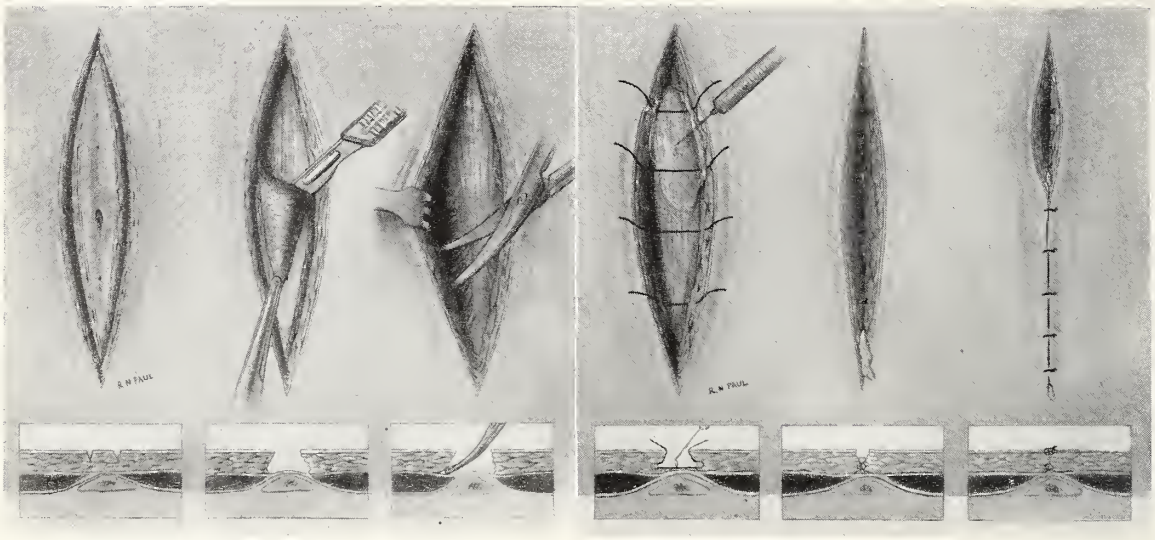
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FIGURE II.

The Plastic Operation for Pilonidal Disease Plus the Use of the Fibrin Clot



1. Excision of Cyst and Undercutting of Subcutaneous Margins.

2. Closure of Wound.
(a) Fibrinogen Solution Instilled after deep sutures are placed.
(b) After tying deep sutures the fibrinogen is converted to a fibrin clot with oddition of few minims of thrombin solution.

skin grafting and for the removal of renal stones encouraged us to continue with our investigation. Sano's [26 27] technique for skin grafting by agglutination of the skin to the bed of granulations by the use of heparinized autologous plasma and leukocytic cream was tried without success. The heparin used in preventing clotting of the autologous plasma was too strong to be neutralized by the weak thromboplastin in the fragmented leukocytes and hemorrhage into the wound occurred. When weaker solutions of heparin were used clotting of the blood specimen usually occurred in the centrifuge. Dried plasma was then tried and was found to form a satisfactory clot with fragmented "buffy coat" in small amounts of saline.

By combining the plastic surgical repair described with the use of the dried plasma and buffy coat solution, healing per primam was readily obtained. As much as three drams of dried plasma was used in the beginning, but this was found to produce a scar so dense as to be almost keloid in character. A reduction in the concentration of fibrinogen content of the plasma was an apparent necessity. A number of other changes were carried out until our present technique was developed. This utilizes pure fibrinogen and thrombin solutions for the formation of the fibrin clot, and appears ideal for our purpose.

Fibrinogen solution,* freshly prepared in 1 to 2 per cent concentrations, are instilled into the wound when it is ready for closure. A minimum of stitches are placed, and the innermost layer of sutures is tied. The excessive fibrinogen is removed from the wound in this manner, but at the same time all raw surfaces are covered with the substance and any remaining crevices have become filled with it. A few minims of thrombin solution is now injected through the stitches, by use of a hypodermic needle, into the deepest layer of the wound. Coagulation of the fibrinogen results by its conversion into fibrin. The remainder of the incision is closed without tension, using a minimum of sutures. The skin is exactly coaptated by "on end" mattress sutures of fine silk (Figure II).

Healing per primam has occurred in twenty patients on whom this procedure was tried (Figure III). There has been one partial failure from infection in which the wound subsequently healed by secondary intention. This was the result of depending upon penicillin to control an infection only four days removed from the acute phase. We believe that there is no substitute for careful surgery, and any procedure is doomed to failure which does not take into account the proved tenants of the "plastic procedure." The fibrin clot is recommended as an adjunct to careful definitive surgery, and as such offers an advantage in healing. It will soon be a year since our first operation was tried, and no failure has been observed to develop in that time other than the one mentioned. When one examines these wounds he is impressed with the sense of sound healing that is obtained.

* We wish to thank the Department of Pathology, Iowa University School of Medicine, for furnishing the beef thrombin for these experiments, and the Department of Physical Chemistry of Harvard Medical School, Boston, Massachusetts, for its cooperation in furnishing the human fibrinogen and thrombin.



FIGURE III.

Appearance of wound of patient, twelve days post-operatively, upon whom the plastic operation was done.

Animal experiments** we have completed reveal that fibrin coagulated in a closed wound is almost immediately invaded with endothelial cells and new capillaries are formed in seventy-two hours. Fibrosis progresses at a normal rate over the scaffold of fibrin until complete healing is obtained in a normal manner (Figure IV). The advantage of the method is that a start of several hours is obtained over the unannointed wound which must await its own tissue juices to form a coagulum bridge before the repair of its lost continuity can be begun. Also, the interstices of the cut surface of the tissues are sealed off by the precipitated fibrinogen, and excess fluid is not formed in the wound. All dead space is eliminated, and the direction of healing is determined immediately when the wound is closed.

** The animal experiments were conducted in the Department of Experimental Surgery, Aero Medical Laboratory, Wright Field, Dayton, Ohio.

RESUME OF TREATMENT

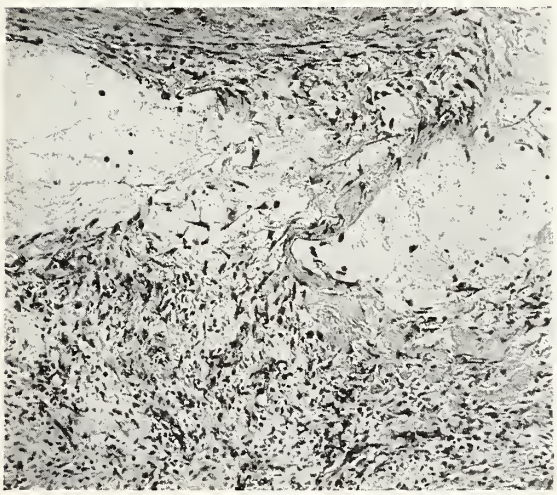
1. *Selection of Patients for Surgery*—Acutely infected pilonidal cysts are only drained, and no definitive surgery is attempted until all infection has subsided. Pilonidal cysts with chronic or quiescent infection are selected for excision and primary closure. Uncomplicated cysts and sacrococcygeal dimples are not operated upon.

2. *The Preoperative Regimé*—This shall include a non-residue diet, establishment of a therapeutic blood level of sulfonamides, enemas until returns are clear two days preoperative, and a twenty-four-hour preparation of the operative field.

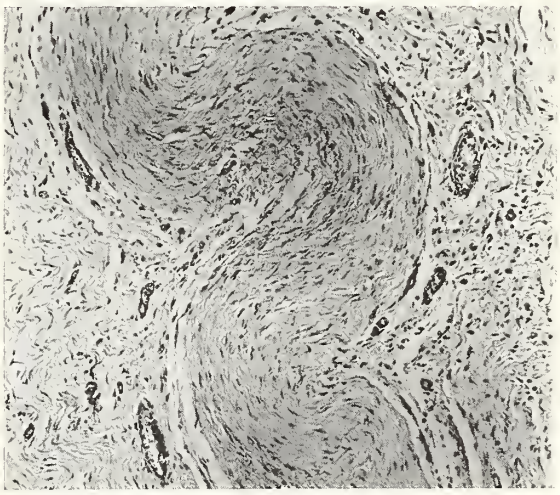
3. *The Operation*—This shall be conducted with the most careful aseptic technique and shall include preservation of all possible skin compatible with complete excision of the cyst and sinuses. Absolute hemostasis is necessary, ties and sutures being of the finest plain catgut, cotton, or silk. Sulfa drugs are not used in the wound. Simple closure in layers without tension is accomplished by undercutting the skin and subcutaneous tissues, the line of cleavage passing just superficial to the gluteal fascia as far lateral as is required. The skin is closed by exact coaptation of its cut edges. No tension sutures are used, but gentle pressure on the external wound surface is maintained by the use of a dressing of mechanic's waste. "Sulfa" powder is used externally to prevent maceration and superficial infection under the dressing. Finally, clotted fibrinogen solution may be added to aid in the healing of the wound.

FIGURE IV.

The Process of Conversion of Fibrin Clot into Tissue (Experimental)



1. Invasion of Endothelial Cell and Capillaries.



2. Formation of Fibrous Connective Tissue—Collagen Fibers.

4. *Postoperative Regimé*—Bed rest for the first week is perhaps desirable. The bowels are allowed to remain quiescent for five days to a week by avoiding laxatives and eating only non-residue foods. The dressing is changed in five to seven days unless the wound requires observation sooner. After the first dressing the heat lamp is used to aid in preventing maceration of the skin. The stitches are removed in seven to ten days, depending upon the condition of the skin edges. The patient can usually be discharged to full duty by the end of the third week.

5. *The advantages offered by the use of coagulated fibrinogen* are numerous. Hemostasis is assured, and the dead space of the wound is filled with a normal substance that facilitates healing. The cut surfaces of the wound are coaptated and the skin flap is agglutinated to the sacrum by a material that accelerates the normal process of repair. This is proved by the speedy formation of new capillaries in the fibrin clot and the actual repair of the tissue defects by the growth of fibrous tissue over the fibrin framework. Finally, this repair is not accomplished by the so-called "inflammatory method" characterized by the invasion of polymorphonuclear leukocytes, but by the primary repair obtained by the invasion of the spindle-shaped connective tissue cells from which develop collagen fibers.

SURGICAL TREATMENT OF UNDESCENDED TESTICLE

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The purpose of this paper is to bring before the medical profession the consideration of a deformity which, in my opinion, is being generally neglected. I believe this to be true in spite of the fact that during the past decade much has been written on the subject, and it is generally accepted that we have methods of treatment which are tried and proved.

The deformity of which I speak is cryptorchidism, and the accepted treatment is the Torek orchiopexy. Cryptorchidism is a relatively common condition. C. M. McKenna[1] states that the condition is found in one out of every five hundred adult males. A. Goetsch[2] states that this condition was found to exist in three of every one thousand adult American males examined for military induction in 1916 and 1917.

Prior to 1900 many methods and types of operations were suggested and tried by various surgeons for the treatment of undescended testicle. In 1881 Schueller[3] advocated division of the processus vaginalis and sutured the testicle to the bottom of the scrotum. In 1889 Bevin stressed the necessity of careful separation of the constituents of the spermatic cord in order to lengthen it. There were various types of purse strings advocated in order to hold the testicle in the scrotum. Elastic bands were used to anchor the testicle to the thigh. Since 1820, when the first orchiopexy was performed, more than forty methods of bringing the testicle into the scrotum[4] have been advocated.

In 1909 an article was published by Franz Torek[5] in which he advocated for the first time the firm anchorage of the testicle to fascia lata of the thigh. This method gave better results in his hands than any other surgeon had reported. Probably because the term orchiopexy rather than surgery for undescended testicle was used, the article did not attract widespread attention. However, the Torek technique was adopted and tried by a few of the workers in this field, with excellent results.

Drs. Carl G. Burdick and Bradley L. Coley, of New York,[6] reported a large series of cases, one hundred and thirty-seven in all, out of which group they reported one hundred and twenty-three excellent results.

Dr. Torek also reported a second series of cases in 1931. There were numerous other workers, including Dr. Hugh Cabot[7] of the Mayo Clinic, who had adopted this method of treatment and reported a number of cases successfully treated, in 1935. There were a great many more who reported very gratifying results at about this same period.

In 1934, S. Cohn[8] reported a successful series of cases treated by anterior pituitary substance and claimed remarkable results in at least a given percentage of patients treated. However, in direct opposition to these findings, Robert E. Cone[9] reports that anterior pituitary substance is of no value and may be dangerous if not very carefully

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[1] McKenna, C. M., and Ewert, E.: Management of Undescended Testicle, *J.A.M.A.*, **105**:1172-1175, (Oct.) 1935.

[2] Goetsch, A.: Undescended Testis: Review of Thirty-two Operative Cases, *Am. J. Surg.*, **12**:63-73, (Apr.) 1931.

[3] Ada, Alexander E. W.: Torek Orchiopexy for Undescended Testis, *Am. J. Surg.*, **23**:133-136, (Jan.) 1934.

[4] Harris, Franklin I.: Treatment of Undescended Testicle: with Particular Reference to Endocrine Therapy and the Torek Operation, *Am. J. Surg.*, **27**:447-454, (Mar.) 1935.

[5] Torek, Franz, Orchiopexy for Undescended Testicle, *Ann. Surg.*, **94**:97-110, (July) 1931.

[6] Burdick, Carl G., and Coley, Bradley, L.. Undescended Testicle, *Ann. Surg.*, 495-500, (Oct.) 1933.

[7] Cabot, Hugh: The Management of the Incompletely Descended Testis, *South. Surg.*, **4**:331-344, (Oct.) 1935.

[8] Cohn, S.: Anterior Pituitary-like Principle in the Treatment of Maldescent of the Testicle, *J.A.M.A.*, **103**: 103-105, (July 14) 1934.

[9] Cone, Robert E.: The Surgical Management of Cryptorchidism, *Ann. Surg.*, **119**:519-594, (Apr.) 1944.

controlled. L. M. Rankin,[10] in a series of cases, found that anterior pituitary substance benefited only 23 per cent of the cases so treated. Clyde L. Deming,[11] of Yale University, stated that 50 per cent of the cases could be benefited by hormone treatment, and that 50 per cent required surgical treatment.

The conclusion reached after reviewing the literature is that the Torek operation is the operation of choice; that hormone therapy may be tried, and that if it fails, then surgery is advisable.

There is apparently no agreement among those handling these cases as to the proper age for elective Torek operation. Burdick and Coley state that it should be done between the ages of eight and twelve; Cabot suggests between the ages of five and nine; and Rankin recommends that the operation be done at five years of age. Others advise that nothing should be done until the age of puberty. It is well known to all who have followed these cases that a great many undescended testicles spontaneously present themselves in their proper position in the scrotum without any treatment.

I have treated surgically approximately twenty-seven cases of undescended testicle: twenty under fifteen years of age, and 7 adults. In the pre-adolescent group satisfactory results were obtained in all cases. In the adult group three were failures. In one case atrophy resulted, apparently due to interference with blood supply; one case developed infection and the testicle was largely destroyed by it; and in the third case an intra-abdominal testicle was found, with a cord so short it could not be brought even into the canal. In the remaining four adults treated very good results were obtained.

I have found the operation usually less difficult in the pre-adolescent group. Tissues are more pliable and the cord is more easily lengthened. These factors, and especially the excellent results obtained in the pre-adolescent group, emphasize the necessity of treating undescended testicle before late puberty or adult age. Personally, I favor the age limits as advocated by Burdick and Coley, namely, between eight and twelve years, unless concurrent hernia requires earlier attention.

Undescended testicle should be given careful consideration for the following obvious reasons: (a) It is extremely important from a psychological standpoint that a boy not be compelled to pass beyond the age of puberty with only one testicle. I think this condition may be a terrific handicap in the mental and social development of the adolescent. A great many such boys are unwilling to mingle with others their own age, especially in the field of school athletic activities, and are inclined to develop an oversensitivity concerning all problems of sex and social relationships with both boys and girls. This may cause him actually to give up any thought of high school or college education. Young adults who have had a successful Torek operation performed have confided the tremendous upsurge of self-confidence and sense of well-being they have experienced. (b) It has been stated by Dr. Hugh Cabot, of the Mayo Clinic, that malignancy is fifty to two hundred times more apt to occur in undescended than in normal testicles. This is thought to be due not to the condition of the testicle, but to the malposition where the temperature is higher than that found in the scrotum. For this reason alone it would seem wise to intervene surgically in these cases. (c) Hernia is found to be associated with the majority of undescended testicles. Wangensteen[12] reported a series of thirty cases operated, in which he stated that all had hernial sacs. A. Goetsch, in a review of thirty-two operative cases, reported that over 90 per cent had accompanying hernia. (d) Proper development and normal spermatogenesis is thought to be much more likely to occur even in the atrophic testicle when it is properly placed in the scrotum.

There are usually considered to be four definite reasons for failure of the testicle to descend: (1) The testicle may be ectopic. It may lie completely within the abdomen, and in such a position it could never enter the inguinal canal. The testicle may at times migrate into the groin in an improper relationship to the inguinal canal. (2) The testicle may be held within the canal by adhesions or scar tissue. (3) The testicle may be undescended due to an open tunica vaginalis, which is to say an open hernial sac. (4) The testicle may be underdeveloped and atrophic, in which case the proper stimulus for descent is not given.

Obviously, if anterior pituitary hormone is to be effective it is most likely applicable to this last group of cases, and I believe that if a small testicle can be palpated in the canal, hormone therapy should be given a trial. It must, however, be carefully watched and carefully controlled, as it is a well-established fact that overdevelopment of the male sex organs may result from its use.

SURGICAL TECHNIQUE

The principle of the Torek operation is firm fixation of the testicle to the fascia lata at the inner side of the thigh. In order to accomplish this, it is practically always necessary to lengthen the spermatic cord by painstaking dissection. The vas deferens and major vessels are usually long enough to reach deep into the bottom of the scrotum after the tunica vaginalis is freed from the cord structures and the connective tissue elements are isolated and severed. The dissection must be carried high, until the fold of tunica which blends with the general peritoneum can no longer be pulled down. Freeing all adhesions and severing all connective tissue bands requires great patience, as well as time, and

[10] Rankin, L. M., and Eger, Sherman A.: Advantages of Early Operation in Undescended Testis, *Am. J. Surg.*, **57**:183-184, (July) 1942.

[11] Deming, Clyde L.: Hormonal and Surgical Bases for Treatment of Undescended Testis, *Am. J. Surg.*, **38**:186-191, (Oct.) 1937.

[12] Wangensteen, Owen H.: The Surgery of the Undescended Testis, *Surg. Gynec. & Obst.*, **54**:219-231, (Feb.) 1932.

extremely careful handling of tissues. Tissues of spider-web-like thickness must be freed from the important elements of the cord and severed. Magnifying lenses may be of great help in this phase of the operation.

The inguinal canal and scrotum are then opened by the fingers being thrust into them. The testicle is pulled down against the thigh to make certain the cord is of sufficient length to reach deep into the scrotum. After the cord is lengthened the testicle and cord may then be wrapped in a wet sponge while the hernia is repaired. A patent tunica vaginalis, if not a definite hernial sac containing omentum, is usually found, and therefore a hernial repair must be done. I have usually been able to do a regular Bassini repair in these cases and still have sufficient cord length to permit the testicle to reach the thigh. If the cord cannot be lengthened, some type of Ferguson repair may be done.

With the sac tied off high and the Bassini repair done, one proceeds with the operation by filling the scrotum with a gauze sponge. A diagonal incision about an inch long is made through the scrotum and a corresponding incision is made in the skin of the thigh. The next step should be the careful placing of a subcuticular silk suture which unites the posterior folds of the incision of the scrotum and the thigh. The testicle is then brought down through the scrotum and attached by two silk sutures through the tunica albuginea and the fascia lata. After these two anchor sutures are tied, interrupted black silk sutures are carefully placed to obtain the best possible approximation of the scrotal skin to the thigh. Particular care should be used for this approximation because of the tendency of scrotal skin to retract, especially at the angles of the wound. The inguinal incision may then be closed. The usual hernial dressing is extended to cover the testicle and the upper part of the thigh, and the sutures are removed after nine to twelve days.

The testicle is allowed to remain anchored from six to twelve months. During this time the patient may engage in any type of activity and need feel no handicap. The second stage of the operation consists of freeing the testicle from the fascia lata, and the scrotum from the thigh. Both wounds are closed and the testicle will then rest in a normal position within the scrotum.

CONCLUSION

Our problem, then, is chiefly one of familiarizing the members of the medical profession with the proper treatment of undescended testicle. Uniformly good results can be obtained, especially when treatment is instituted before the age of puberty. The Torek orchiopexy is the operation of choice and may be used in conjunction with anterior pituitary therapy.

ABSTRACT: ATOMIC BOMB ILLNESS CAUSES DISTURBANCE IN BODY FUNCTION

Destruction or suppression of the blood formation system and disturbance in liver function are the primary results of what the Japanese call atomic bomb disease, according to Col. Paul D. Keller, Medical Corps, Army of the United States.

Writing in the June 8 issue of *The Journal of the American Medical Association,* Dr. Keller reports on the study he made of twenty-one patients suffering delayed symptoms of this malady at the Osaka University Hospital. Seventeen of the patients experienced the atomic bombing at Hiroshima, Japan, on August 6, 1945, while the remaining four were victims of the Nagasaki explosion on August 9, 1945.

Although the illness results to some degree from a generalized disturbance in the human physiologic function, the author found that the effects on the blood formation system were: reduction of the white corpuscles in the blood, decrease in the number of blood platelets (the nature and role of which are still obscure but they are thought to be factors in the clotting of blood), increased bleeding time and hemorrhagic tendencies with a resulting anemia, fever, and weakness. The general effect on the liver caused a deficiency of proteins in the blood with jaundice and fever.

These patients do not include those receiving severe blast injuries or extensive external burns at the time of the explosion. Seventeen of the patients received minor wounds or burns, while four were uninjured at the time. These wounds resulted from flying splinters, glass, and other debris or falls.

Loss of appetite, nausea and vomiting of varying severity and length of duration were common early symptoms. The onset of these symptoms occurred within the first five days after the explosion. Twelve patients complained of fever, the onset of which ranged from two to twenty-five days after the explosion.

Unusual and in several instances considerable loss of hair from the scalp was experienced by thirteen of twenty-one patients. The author also states that eleven patients displayed unusual hemorrhagic tendencies during the course of their illness.

"Fatigability was almost a universal complaint," Dr. Keller writes. "This was mild as a rule following the bombing, but increased in severity to become actual weakness in most patients by the time they were admitted to the hospital."

Other symptoms complained of by individual patients were faintness, tightness in the chest, dizziness, difficulty in swallowing, and unusual thirst.

Among the most spectacular findings noted by the author were involvements such as different types of anemia and the reduction of white blood corpuscles in the blood. In general there was extensive tissue destruction within the body similar to that following excessive irradiation of the body with x-rays.

Five patients died within an average of twenty-six days after the bombing. Those who survived required long periods of hospitalization before their recovery was sufficient to warrant a hospital discharge, Dr. Keller's study reveals.

The article finds the environmental location of each patient at the time of the explosion especially significant. The distance of the patients from the center of the explosions ranged from 50 to 4,000 meters (approximately two and one-half miles). Seventeen of the twenty-one patients were in buildings at the time the bomb exploded. Fourteen of the seventeen patients were in wooden buildings, while the other three were in concrete buildings.

Questioning revealed that only five patients recalled experiencing a definite concussion wave at the time of the explosion.

CLINICAL OBSERVATIONS ON THE USE OF PENICILLIN

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Our penicillin section was opened in November, 1943. At first our use of the drug was confined almost entirely to the treatment of gonorrhea. Since that time we have treated one thousand twenty cases of this disease.

Until March, 1944, we treated these cases by giving 10,000 units every three hours intramuscularly for five doses. If this failed to cure the disease, as demonstrated by smear and culture after a five-day period of observation, the patient was re-treated, using 10,000 units intramuscularly every three hours for ten doses. We had one hundred eighty-eight cases which were cured by the initial treatment of 50,000 units. Thirty-six cases were cured upon receiving the second course of 100,000 units; in three cases in which there were chronic, long-standing complications, two were cured by receiving 350,000 units over a three-day period; and in one we failed to cure after using 350,000 units.

We had one case of gonorrheal ophthalmia which was treated locally and intramuscularly, with the edema, injection, and discharge from the eye disappearing within four days. The culture became negative after five days of penicillin treatment.

We were authorized in March, 1944, to treat these cases with 100,000 units, giving 20,000 units every three hours, intramuscularly, for five doses, and if this failed to cure, to repeat the procedure as many as three times if necessary. We have treated seven hundred ninety-two cases since then, and in only twenty-six instances has it been necessary to give more than the initial course. These twenty-six cases were all cured, as indicated by negative smears and culture, after the second course of 100,000 units.

The second group of cases were observed for seventy-two hours, and if their smears were negative at that time they were released. We have no way of knowing how many have had a relapse at a later period, but the number of relapse cases entering our hospital after having been treated elsewhere has been very small. Recently we have been using 50,000 units intramuscularly every three hours for four doses.

Mahoney,[1, 2] Moore,[3] Stokes[4] and others have been carrying on extensive studies on the effect of penicillin in various types of syphilis. Their observations are not completed at the present time. Surface lesions of syphilis disappear very rapidly under penicillin, and in a certain number of cases there is a tendency toward serologic reversal, while in others the serology tends to revert to positive after being negative for a period of time. We are now treating primary, secondary, latent, and arsenic- or bismuth-sensitive cases of syphilis exclusively with penicillin. The prescribed treatment consists of 40,000 units intramuscularly every three hours for sixty doses, which runs over a period of seven and one-half days and gives a total dosage of 2,400,000 units.

We have treated a total of forty-eight cases and have not been able to follow them, for as soon as their lesions subside and they are no longer infectious they are sent back to their units to be followed by the medical officers of their organization.

In the pneumonias due to pneumonococcus, beta streptococcus and Staphylococcus aureus we have had uniformly good results in treating them with penicillin. The temperature usually falls by lysis, occasionally by crisis, and in almost every instance the patient is objectively and subjectively improved within twenty-four to forty-eight hours. The resolution of the infiltration in the lungs ordinarily does not proceed at a more rapid rate than when a sulfonamide is used, usually requiring from one to three weeks for complete clearing of the pneumonic process. In all, we have treated one hundred twenty-three cases of the various types of pneumonia. There were a number of cases in which no bacteriological agent could be demonstrated that responded favorably to penicillin therapy. Fifteen cases ultimately diagnosed as primary atypical pneumonia failed to respond to the drug.

The usual method in treating these cases of pneumonia is to use 25,000 units every three hours for three doses and then give 15,000 units every three hours from three to five days after the temperature reaches normal. We treated approximately twenty-five of the cases of pneumonococcus pneumonia by giving 200,000 units in normal salt solution by continuous intravenous drip for twenty-

[1] Mahoney, J. F.; Arnold, R. C.; and Harris, Ad; Penicillin Treatment of Early Syphilis; A Preliminary Report, *Ven. Dis. Inform.* **24**:355-357 (Dec.) 1943: *Am. J. Pub. Health.* **33**:138701391 (Dec.) 1943.

[2] Mahoney, J. F.; Arnold, R. C.; Sterner, B. L.; Harris, Ad; and Zwally, M. R.: Penicillin Treatment of Early Syphilis: II., *J.A.M.A.* **126**:63-67 (Sept.) 1944.

[3] Moore, J. E.; Mahoney, J. F.; Schwartz, Walter; Sternberg, Thomas; and Wood, W. B.: The Treatment of Early Syphilis with Penicillin; a Preliminary Report of One Thousand Four Hundred and Eighteen Cases, *J.A.M.A.* **126**: 67-73 (Sept. 9) 1944.

[4] Stokes, J. H.; Sternberg, T. H.; Schwartz, W. H.; Mahoney, J. F.; Moore, J. E.; and Wood, W. B., Jr.: The Action of Penicillin in Late Syphilis Including Neurosyphilis, Benign Late Syphilis and late Congenital Syphilis: Preliminary Report, *J.A.M.A.* **126**:73-79 (Sept. 9) 1944.

four hours after the diagnosis was made. The majority of these cases recovered promptly without any further therapy, but in a few it was necessary to give a second course of treatment of 200,000 units before a satisfactory response was obtained. Personally, I favor using the intramuscular route and continuing treatment until the temperature has been normal for three to five days.

Two cases of nonputrid lung abscess which developed as a complication of pneumonia were treated until the cavity showed signs of clearing. Both of these cases went on to complete clearing in approximately fifty days.

We have treated nine cases of infectious mononucleosis in which there was severe, secondary infection of the throat. Six of the cases had rapid clearing of the throat inflammation, while three of them were unaffected. In none of the cases was there any effect on the primary disease. We feel that in this disease, when there is severe, secondary infection of the upper respiratory tract, the use of penicillin is justified in trying to control the process and make the patient more comfortable.

Superficial streptococcus infections usually respond very rapidly to penicillin therapy. Eight cases of erysipelas have been treated with almost dramatic cures in each instance. The temperature falls to normal within twenty-four to forty-eight hours, and there is very rapid clearing of the erythema and edema.

Nine cases of scarlet fever have been treated by the intramuscular method with satisfactory results in eight of them. The other case was treated for five days, and all signs of the disease had disappeared, but within twenty-four hours after the treatment was discontinued the throat again became injected and edematous and was positive by culture for beta streptococci. He was again treated for six days, and on terminating the penicillin there was a recurrence of the angina and streptococcus in his throat.

We feel that it is important in scarlet fever and in any acute exudative throat infection to continue penicillin treatment for at least seven days, for we have had the experience on several occasions of having the inflammatory process recur after stopping treatment on the third or fourth day.

We have had many cases of severe, prostrating, exudative tonsillitis and pharyngitis due to beta streptococcus and other gram-positive organisms normally found in the throat which have been treated with penicillin with uniformly good results. The temperature usually falls to normal within twenty-four to forty-eight hours, and the exudate and injection will clear within three or four days.

We have treated meningococcus meningitis by giving 10,000 units of penicillin in 10 cc. of normal salt solution intrathecally every twelve hours for forty-eight hours, then 10,000 units once daily until the spinal fluid findings are nearly normal and three negative cultures are obtained. We also give 200,000 units intramuscularly during each twenty-four-hour period. Our experience with penicillin in the treatment of this disease has been variable. The first two cases failed to make satisfactory response after several days of treatment and were ultimately changed to sulfadiazine with a prompt clearing of the disease. The next three cases responded satisfactorily. Two cases were started on sulfadiazine and developed severe hematuria which necessitated substituting penicillin for the sulfadiazine; both of these cases recovered promptly. We have two current cases, one due to meningococcus, and in the other we have been unable to demonstrate the etiological agent, in which it has been necessary to use sulfadiazine and penicillin together in order to effect recovery.

A case of Waterhouse-Friderichsen syndrome due to meningococcus bacteremia was treated with penicillin and large amounts of plasma and cortical extract. After a critical and stormy course recovery was complete, and undoubtedly due, primarily, to the penicillin controlling the blood stream infection.

We have used penicillin in treating six cases of pleurisy with effusion. Five developed as a complication of pneumonia, and one as a complication of splenectomy. The results were disappointing in four cases, and satisfactory in two.

Under the influence of penicillin the fluid will usually remain sterile and relatively serous, but absorption is not hastened. It is our impression that after three to four weeks, if the fluid is not definitely lessened and the mediastinum is fixed, surgical drainage should be considered.

Three cases of bronchial asthma and bronchiectasis have been treated with aerosol penicillin. This was done by connecting oxygen with a nebulizer, which in turn was connected with an oxygen mask. One cc. of salt solution containing 5,000 units of penicillin was placed in the nebulizer and oxygen allowed to flow through the system at the rate of four liters per minute. Approximately 1 cc. of the penicillin solution was nebulized in a five-minute period. The patient used the mask for five minutes out of each hour throughout the day. This type of treatment caused the disappearance of the penicillin-sensitive organism in the sputum, but the underlying pathology was unchanged. Several articles [5, 6] have appeared in the literature recently which reported favorably on this method of treating acute and chronic respiratory infections.

We have had relatively good success in treating pyodermias due to hemolytic Straphylococcus aureus. Carbuncles and furunculosis usually respond very rapidly to penicillin therapy. Impetigo and other types of pyodermia respond less rapidly, but it is felt that these conditions do respond better

[5] Vermilye, Herbert N.; Aerosol Penicillin, *J.A.M.A.* 129:250 (Sept. 22) 1945.

[6] Hagens, W. W.; Karp, Mary; and Farmer, C. J.: Inhalation Method for Penicillin Therapy, *Arch. Otolaryng.*, 41:333 (May) 1945.

to penicillin therapy than to other types of treatment which have been used previously.

Two cases of acute thrombophlebitis involving the lower extremities responded very well to penicillin. There was marked tenderness along the course of the femoral and saphenous vein, with tenderness and edema of the foot, ankle, and leg. These signs cleared during the first seventy-two hours of treatment, with recovery complete after five days.

The most interesting and unusual case which we have treated is one of cecal and pulmonary actinomycosis. The disease developed following an operation for appendicitis. Two sinuses in the right lower quadrant developed, along with one later on in the disease in the right lumbar region. A ten-inch granuloma in the head of the cecum and numerous areas of nodular infiltration in both lungs were demonstrated by x-ray. He was treated with sulfadiazine for some time, and when the organism became sensitive to penicillin it was added to the therapy. He was treated for one hundred fifteen days with doses varying from 120,000 to 200,000 units per day, intramuscularly. The sinuses were also injected daily with a solution containing 250 units per cc. The patient was markedly emaciated at the time of admission and gained forty-five pounds while under treatment. All signs of the disease have disappeared except minimal scarring in the cecum, as demonstrated by x-ray. The patient was kept under observation for one year after treatment was started, and at the time of discharge showed no signs of recurrence of the disease.

In the spring of 1944 one of our staff suggested that penicillin might be of value in the treatment of Vincent's gingivitis and angina since it had been shown to be effective against the spirochaetae of syphilis and relapsing fever.[1, 7] These cases were first treated with a normal saline solution containing 250 units of penicillin per cc., applied topically to the gingiva three or four times a day. It required an average of three to four days for the lesions to disappear and the smear to become negative for Bacillus fusiformis and spirilla. At the present time we treat the gingivitis cases by spraying the lesions every three hours with a normal saline solution containing 500 units per cc.

We [8] have studied two cases of Vincent's angina where only a solitary ulcer was present on the tonsil. Giving 15,000 units intramuscularly every three hours, there was a progressive fall in the number of spirilla and fusiform bacilli present until, six hours after treatment was started, they had all disappeared. The spirilla and fusiform bacilli did not recur in the throat smears which were checked daily for ten days. It required seven to ten days for the pseudomembrane to disappear and the ulcer to heal. The normal bacterial flora of the mouth and throat was present after the organisms of Vincent disappeared.

At present the Vincent's angina cases are treated by giving 20,000 units intramuscularly every three hours for five doses.

We have treated three thousand six hundred patients in the two years we have had our department. Approximately two-thirds of these cases have been surgical conditions, excluding the venereal disease group.

Its use in genito-urinary surgery has been to clear the infection prior to operation when one was dealing with a susceptible organism or to prevent infection by its administration before and after operation. Prophylactically, it is given for forty-eight hours before and for five to seven days after operation in doses of 10,000 to 15,000 units every three hours, intramuscularly.

Our experience in gynecology has been limited to gonorrheal and nonspecific pelvic inflammatory disease. If the patient is having her first acute attack of a specific infection, we administer 25,000 units every three hours intramuscularly for a total of 5 to 600,000 units. The smear and culture will become negative at the end of twenty-four hours of treatment; the symptoms of the disease will clear in three days; and the palpable evidence of the disease will usually disappear in seven days.

In nonspecific infections, if one is dealing with a susceptible organism, the acute process will usually subside at a slower rate than in the gonococcal case and complete recovery will usually be attained. In chronic pelvic inflammatory disease with acute exacerbation penicillin will cause the acute phase to subside, but pelvic surgery must be resorted to if an ultimate cure is desired.

Acute infections involving the eyes are definitely benefited in most instances by penicillin. It can be considered almost a specific drug in the treatment of orbital cellulitis. Incision and drainage is usually not necessary in these cases when penicillin is used.

Sinusitis does not seem to respond well to penicillin therapy in most cases. Chronic otitis media and mastoiditis do not react satisfactorily to penicillin. Adequate surgery is usually necessary, but penicillin is a valuable adjunct to mastoid surgery.

Penicillin has not been of much aid in abdominal surgery, as the offending organism is usually one that is not affected by penicillin. However, acute, superficial, localizing infections of the head and torso, and ascending infections of the extremities show rapid recovery in nearly every case. By using penicillin in cases of severe infections of the hands and feet, mutilating surgery resulting in loss of function is avoided.

In acute osteomyelitis penicillin has been quite effective. The original report by the Oxford in-

[7] Heilman, F. R., and Herrell, W. E.: Penicillin in the Treatment of Experimental Relapsing Fever, *Proc. Staff Meet., Mayo Clin.* **18**:457-467 (Dec. 1) 1943.

[8] Shallenburger, Paul L.; Denny, Earl R.; and Pyle, Harold D.: The Use of Penicillin in Vincent's Angina, *J.A.M.A.* **128**:706 (7 July) 1945.

vestigators[9] contained a case of acute hematogenous osteomyelitis of the left femur with staphylococcus bacteremia. After receiving a total of 17.2 grams of penicillin a satisfactory result was obtained. In a subsequent report by Florey and Florey,[10] they pointed out that rarefaction of bone increases with clinical improvement, and that the roentgenologic appearance of bones in osteomyelitis should be interpreted in the light of this observation.

Altemeier[11] reported six cases of early acute osteomyelitis in which surgical drainage was necessary in only two. He pointed out that there is evidence, if penicillin is administered early before thrombosis of the nutrient vessels has occurred, that open operation may be unnecessary in many cases.

In suspected acute osteomyelitis it is important to continue treatment for some time after clinical cure is apparent, as the penicillin may cause the x-ray evidence of localized bone infection to be absent or considerably delayed. We have had only three cases of acute osteomyelitis; two of them had bacteremia, and two recovered without operative interference.

Our plan of treatment has been to give 300,000 units per day by the continuous intravenous drip method until the bacteremia and the acute phase of the disease has passed; then to give 100,000 to 200,000 units of penicillin per day, intramuscularly.

When we first began to use penicillin we had hopes that it would be effective in chronic osteomyelitis, but we were soon disappointed. The susceptible organisms would usually disappear from the exudate of the wound. The discharge would lessen in amount and often become serous in character, but on withdrawal of penicillin therapy recurrence of active infection and drainage would take place.

The concensus[12] indicates that in the treatment of chronic osteomyelitis, surgical drainage, including sequestrectomy and so forth is essential even though penicillin is employed.

We have used penicillin in compound fractures, particularly of the long bones, to permit primary or early secondary closures. So far our results have been very satisfactory. The greatest use of penicillin in the orthopedic service has been in the prophylactic pre- and post-operative care of their patients. They have found it of considerable value whether or not the patients harbor evident infection. We give 10,000 units every three hours intramuscularly for two or three days before operation, and for five to seven days after operation.

In using a specific agent one is likely to neglect the other measures that should be employed in treating serious infections. It is important that careful attention be given to general supportive procedures, such as the use of transfusions, plasma, parenteral fluids, oxygen, vitamins, and any other measures which may enhance the activity of the patient's normal defense mechanisms.

The suggestions given concerning dosage and general principles in the management of the various diseases are based on accumulated experience to the present time. Although they may serve as a guide in the application of penicillin therapy, good clinical judgment, proper surgical principles in surgical conditions, variations in dosage, methods of administration, and length of treatment should be exercised in the management of the individual case.

[9] Abraham, E. P.; Chain, E.; Fletcher, C. M.; Gardner, A. D.; Heatley, N. G.; Jennings, M. A.; and Florey, H. W.: Further Observation on Penicillin, *Lancet.* 2:177-188;189 (Aug. 16) 1941.

[10] Florey, M. E., and Florey, H. W.: General and Local Administration of Penicillin, *Lancet.* 1:387-397 (Mar. 27) 1943.

[11] Altemeir, W. A.: Penicillin in Surgery, *South. M. J.* 37:494-506 (Sept.) 1944.

[12] Herrell, Wallace E.: *Penicillin and Other Antibiotic Agents.* W. B. Saunders Company, 1945.

ABSTRACTS

DICUMAROL DELAYS BLOOD CLOTTING IN HEART DISEASE

A preparation of spoiled sweet clover has been used successfully to delay clotting of the blood in patients with coronary thrombosis. Three investigators, comparing an untreated group with a treated group of patients, found that this drug reduced the death rate.

Writing in the February 16 issue of *The Journal of the American Medical Association*, the three investigators—H. Raymond Peters, M.D., J. Roy Guyther, M.D., and Charles E. Brambel, Ph.D., of Baltimore—say that of the sixty patients treated in the usual routine manner with bed rest, thirteen died. Of the fifty treated with dicumarol, the spoiled sweet clover drug, only two died.

These one hundred ten cases were studied during the last three years at the Mercy Hospital, in Baltimore. The investigators are from the Departments of Medicine and Clinical Biochemistry, Mercy Hospital Division, University of Maryland School of Medicine.

In coronary thrombosis a clot forms in one of the coronary arteries, or more frequently in one of the branches, and a portion of the heart muscle is deprived of blood for a length of time sufficient to do damage. The seriousness of the accident depends on the size and location of the branch blood vessel which is stopped up by the clot.

The authors say that they observed an increased clotting tendency in most of their cases of acute coronary thrombosis. Dicumarol, which was discovered when hemorrhagic disease was studied in cattle, reduces the occurrence of complications by delaying the clotting of the blood.

In conclusion, the authors say that the drug can be administered for an indefinite time as ill effects were not noted.

MESENTERIC CYSTS

PAUL B. ARBOGAST, M.D.

VINCENNES

Of all abdominal tumors, mesenteric cysts probably are the rarest. The first known case was described by Benevieni,[1] a Florentine anatomist, in 1507; it was found during the performance of an autopsy, and was called a "callus." Various writers state that about five hundred cases have been reported in the literature. The Mayo Clinic reported eight cases in 820,000 admissions, and from 1900 to 1926 the Massachusetts General Hospital reported six cases.[2]

The history of mesenteric cysts may be divided into four periods.[3] During the first period, from 1707 to 1850, the lesion was discovered only at autopsy. In the second period, from 1850 to 1880, an occasional operation was performed for this condition, but there were no recoveries. In the third period, from 1880 to 1890, operations were followed by occasional recovery; and in the fourth period, from 1900 on, this condition became more definitely known, was more successfully treated, and was occasionally recognized before operation.

Roller[4] describes a true mesenteric cyst as one which must occur between the leaves of the mesentery or under the serosa of the intestine, and must not be a retroperitoneal cyst, although it may have originated from retroperitoneal tissue and migrated to a position between the leaves of the mesentery. Cysts occuring under the peritoneum of the abdominal wall may have similar origin, but are not mesenteric cysts by location.

Many theories have been advanced in an effort to explain the presence of these cysts.[2] The idea of stasis and retention of lymph was advocated by early writers; some have attributed them to obstruction of the various lymph channels. These theories are undoubtedly not tenable because of the presence of an extensive lymph anastomosis. The experimental work of Hertzler revealed only a peritoneal exudate after complete ligation of the thoracic duct. This exact mode of formation may depend on the as yet unexplained phenomena involving the formation of lymph.

There is no limit to the size that these tumors may attain. They may be so small as to be unrecognizable, or large enough to fill the abdominal cavity completely. The majority of cysts are unilocular; a small percentage are multilocular. A duct may exist which connects one cyst with another, or a cyst with the intestinal lumen. The walls are of fibrous tissue in which there are many round cells or lymph follicles and often dilated lymph spaces. Bundles of smooth muscle may be present. The lining of recognizable endothelium may be hyperplastic. Many giant cells form about fatty detritus. The cellular lining may be lost. The fluid may be clear, colorless, yellow, milky, mucinous, brown, or bloody. The reaction is usually alkaline. It may contain large quantities of albumin, cell debris, blood, and cholesterin. Malignant degeneration is rare.

These tumors may occur in any position along the intestinal tract from the duodenum to the rectum; the greater number occur in the lower jejunum and ileum. They have been found in individuals of all ages, from fetal to octogenarian;[2] they are commonest in the fourth decade, and are twice as common in the female as in the male.

There are several classifications of these cysts, but the most practical is that of Moynihan,[5] who classifies them according to their contents: (1) serous cysts; (2) chyle cysts; (3) hydatid cysts; (4) blood cysts (usually traumatic); (5) dermoid cysts; (6) gas cysts; and (7) malignant disease with cystic degeneration.

There are no pathognomonic signs or symptoms of mesenteric cyst, pain being, perhaps, the most frequent and predominating symptom. Any abdominal tumor which is round, smooth, cystic, and mobile should suggest the possibility of this entity. There is frequently a history of repeated pain, nausea and vomiting, sometimes associated with alternating periods of diarrhea and constipation. Symptoms of intestinal obstruction may be present and may present the first warning symptom. In a review of sixty cases the diagnosis of mesenteric cyst was made in only four instances. Roentgen ray of the gastrointestinal tract may be of some value in showing pockets of gas or areas of distortion if the tumor is present.[3]

The treatment of mesenteric cyst is always surgical, and with acute obstruction presents itself for emergency measures. The surgeon has the choice of five procedures: drainage, aspiration, marsupialization, enucleation, and resection of the portion of the intestine and mesentery in which the cyst is located. The first three methods are considered unsatisfactory and do not give consistently-good end results. Drainage usually leaves a draining sinus. Aspiration temporarily relieves the condition, which then recurs. Marsupialization is recommended only when the condition of the patient will not allow extensive surgery. Enucleation is the method of choice when the cyst can be shelled

[1] Benevieni, H.: *De abditis nonnulis ac mirandis marboram et sanatiorium causis.* Florentine, 1507.

[2] Larkin, F. L.: Mesenteric Cysts. *Penn. M.J.*, **43**:1446-1448, 1940.

[3] Krass, I.: Mesenteric Cysts. *Rev. Gastroenterology*, **9**:829, 1942.

[4] Roller, C. S.: Mesenteric Cysts. *Surg. Gyn. Obs.*, **60**:1128, 1935.

[5] Moynihan, G. B. A.: Mesenteric Cysts. *Ann. Surgery*, **26**:1, 1897.

from between the leaves of the mesentery without damage to the adjoining intestine or impairment of the circulation. In a majority of cases resection of the cyst-bearing area is necessary and gives uniformly-good results. The prognosis in these cases is quite favorable since the tumor is purely benign.

CASE REPORT

The patient, Mrs. T. E., a white female, aged 37, was seen at her home one Sunday afternoon. She was quite sick and had been suffering from nausea and vomiting for several hours, a condition which she attributed to food indiscretion at a beer party the night before. When seen, she was in shock, with an enormously-distended abdomen. She was hospitalized at once, with a tentative diagnosis of "pregnancy complicated by bowel obstruction." The patient had delivered a normal, full-term infant fourteen months before this onset. She stated that her distress began about a year prior to her acute attack, when she noted some enlargement of her abdomen with some slight intestinal distress. The enlargement gradually increased until its present size was attained. Her menses throughout had been normal, of a 28/4 type. The patient's past history was negative. She had had the usual childhood diseases with good recovery, and one attack of non-surgical appendicitis at the age of thirteen. Her menstrual history was entirely negative. She had delivered three full-term, normal infants, aged respectively, fourteen years, three years, and fourteen months. Her family history was negative except for the fact that both parents are deaf mutes. There was no other familial abnormality.

On admission, urinalysis was negative; R.B.C. 3,420,000; Hb. 10 gms.; W.B.C. 11:500; neutrophils, 67 per cent; Mazzini test was negative; A-Z test was negative on two specimens, and A. P. and lateral x-ray films of the abdomen were negative. Physical examination was essentially negative except for the usual findings of moderate shock, and for the abdominal enlargement which simulated that of an eight- or eight-and-one-half-month pregnancy. Pelvic examination revealed a normal cervix, but the bimanual examination was unsatisfactory due to the great size of the abdomen.

The patient was given conservative treatment, under which her general condition improved, and after a week was released to her home for a two-week period, during which time she was given further supportive treatment.

At the end of two weeks she was readmitted for surgery. There was no appreciable change in either the laboratory or physical findings, except for an improved general physical condition. There where no distinguishable masses, and the enlargement was quite firm and fixed. The tentative diagnosis was changed to "abdominal cyst" of possible ovarian or mesenteric origin. (The possibility of pregnancy was still considered by one consultant, in spite of negative A-Z and x-ray findings and the absence of palpable fetal parts.)

Exploratory laparotomy was performed under spinal anesthesia. On opening the abdomen an immense cyst was encountered, filling the entire abdominal cavity. It was grey in color and distended with fluid. It was not connected with the pelvic organs in any way, the uterus, both tubes, and ovaries being entirely normal. Densely-adherent omentum covered the upper half of the cyst wall. The omentum was freed with difficulty and the cyst wall was opened and the contents evacuated to facilitate removal of the tumor. The cyst contained two gallons of a thin, slightly-cloudy, yellow-colored fluid, with some blood clots and fibrinous debris. The omentum was dissected further, and the attachment of the cyst found to be in the upper jejunal mesentery, near the terminal portion of the duodenum. Due to the nature of the attachment and its intimate adherence to vital structures, complete removal was deemed inadvisable. About nine-tenths of the cyst wall was removed, and the edges of the remaining portion everted. The wound was then closed in layers without drainage.

Postoperative progress was exceptionally good, with an uneventful recovery, the patient being released in two weeks. Examination at intervals over a year's period were negative, the patient being in excellent condition with no evidence of any recurrence.

The pathological report showed a monocular cyst wall of dense, fibrous connective tissue with frequent cholesterol clefts. No definite lining epithelium was apparent. There was no evidence of malignancy. Diagnosis was that of a "cyst wall, unclassified." A report from a second source was similar, with a diagnosis of "mesenteric cyst from location."

ABSTRACT: IRON DEFICIENCY ANEMIA MISTAKEN FOR VITAMIN B COMPLEX DEFICIENCY

Iron deficiency anemia is frequently confused with vitamin B complex deficiencies, according to William J. Darby, M.D., of Nashville, Tennessee, writing in the March 30 issue of *The Journal of the American Medical Association.*

Dr. Darby, who is from the Department of Medicine, Vanderbilt University School of Medicine, presents the case reports of six patients who showed no abatement of symptoms after treatment with B vitamins. These same patients were then treated with iron and almost immediate improvement was noted.

Iron is a necessary part of hemoglobin, the red coloring matter of the blood. The symptoms of iron deficiency are manifested by a mild anemia, inflammation of the tongue and sometimes an inability to swallow. Iron deficiency anemia are more common among women than men.

THE TONSIL STUMP AND ITS REMOVAL

CARL B. SPUTH, JR., M.D.

CARL B. SPUTH, SR., M.D.

INDIANAPOLIS

Tonsil operations are the most frequent surgical procedures done in the United States. It has been estimated that one-third of the children at the age of sixteen years have had tonsillectomies. However, it is our opinion that many of these operations are incomplete, and as a result tonsil stumps remain. These stumps may serve as a foci of infection, and thus are a menace to the health of the individual. We will confine our discussion to such cases which have had one or more tonsillectomies performed.

CAUSES OF TONSIL STUMPS

W. H. Turnley[1] believes that the main cause of tonsil stumps is incomplete operation. He is also of the opinion that possibly the lingual tonsil may hypertrophy and grow up into the tonsil fossae. However, it is the theory of Lechin and Pearlman[2] that tonsillar recurrences are not always due to faulty technique. They proved embryologically that the tonsil plica is intimately concerned with the formation of the tonsil. Thus, lymphoid tissue can regenerate if the plica is not removed.

It is our opinion that the failure to completely remove the tonsillar tissue and the lingual tonsils accounts for the majority of tonsil stumps. Poor light, incompetent assistants, carelessness, and failure to thoroughly inspect the entire fossa all play an important part in not completely removing all tonsillar tissue during the operation.

INCIDENCE OF INFECTED TONSIL STUMPS

The incidence of tonsil stumps varies with different authors. E. H. Campbell[3] reports that 77.3 per cent of the patients had tonsillar remnants in the cases he examined. He also stated that in those children having tonsillectomies before the age of four, 100 per cent have tonsil tissue remaining.

J. D. Kelly[4] states that 73 per cent of the Sluder operations for tonsillectomy are incomplete. According to A. D. Kaiser,[5] 381 out of 1,000 tonsillectomized children had tags. Selkirk and Mitchell's[6] incidence is 18 out of 130 cases, or 13.8 per cent have tonsil tags. Rhoads and Dick[7] report that 290 of 403, or 73 per cent of the nurses at the Presbyterian Hospital, in Chicago, had tonsil stumps.

We have made a record of all new cases seen in our office who have had tonsillectomies. The cases cover an eleven-month period from February 1, 1945, to January 1, 1946.

Total number of cases examined: 285.

	Number	*Percent*
Cases with tonsil stumps (one tonsillectomy)	217	76.5
Cases with tonsil stumps (two tonsillectomies)	10	2.85
Cases with tonsil stumps (three tonsillectomies)	1	.28
Cases with tonsil stumps (total)	228	80.0

According to our records, at least three-fourths of the patients who have had tonsillectomies have infected tonsil stumps and lingual tonsils. Thus, instead of eliminating the foci of infection in the throat, many tonsillectomized patients are still absorbing toxins and are systemically much worse than prior to their operations.

PATHOLOGY

Dr. A. Greifenstein[8] reports definite pathological changes in the blood vessels and tissues of the tonsils and neck in chronically-infected tonsils. Sections showed that the tonsillar crypts contained bacteria, the streptococcus predominating. The veins in the tonsils, neck, and in particular the jugular vein, showed an inflammation and infection of the intima leading to a phlebitis. It is his opinion that phlebitis of the veins in the neck are secondary to a periphlebitis of the pterygoid plexus. The lymph nodes and channels also were chronically infected and showed pathological and histological changes.

In 1928, Dr. Paul Rhoades and Dr. George Dick made a comprehensive study of tonsil stumps in nurses. They found that the bacteria count in tonsil stumps averaged 30 per cent higher than the bacteria count of infected tonsils.

They found that in the stumps fibrous tissue divided the lymphoid tissue into islands. This produced dilated crypts shut off from the surface and filled with debris. Ulceration was found in

[1] Turnley, W. H.: The Secondary Adenoid and Tonsil Operation, *Conn. M. J.* **4**:447-449, 1940.

[2] Lechin, N., and Pearlman, S. J.: Are Tonsil Recurrences Entirely Due to Faulty Operative Technic? *Arch. of Otolaryng.* **13**:37-46, (Jan) 1931.

[3] Campbell, E. H.: Local Results of Tonsillectomy, *Arch. of Otolaryng.* **30**:863-87, (Dec) 1939.

[4] Kelly, J. D.: Choice of Operations in Tonsillectomy; *Laryngoscope*, **47**:7-13, (Jan) 1937.

[5] Kaiser, A. D.: Results of Tonsillectomy; Study of 2,200 Cases, *J.A.M.A.* **95**:837-842, (Sept. 20) 1940.

[6] Selkirk, M. K., and Mitchell, A. G.: Evaluation of the Results of Tonsillectomy and Adenoidectomy, *Am. J. Dis. Child*, **42**:9-41, (July) 1931.

[7] Rhoads, P. S., and Dick, G. F.: Efficiency of Tonsillectomy for the Removal of Focal Infections, *J.A.M.A.* **91**:1149, (Oct. 20) 1928.

[8] Greifenstein, A.: Pathologic Isch-Anatomische Untersuchung Thrombotische Entzuendlicher vor Gaenge im Hals-venen-System, *Virchows Archiv.*, **281**: 1931.

the tonsil stumps which had the highest bacterial count.

Cultures of the bacteria from tonsil stumps were made, and this material was inoculated into dogs. The dogs became ill and tended to produce the type of lesion found in the human being from whom the stumps were removed. The most frequent type of lesion was arthritis.

The following is a summary of the pathology of tonsil remnants, as found by Dr. Horace Banks, the pathologist at the Methodist Hospital:

"The external surface of the tonsil shows either fibrosis or a marked thickening of the squamous epithelium. The zone of lymphoid tissue often shows degenerative changes in the germinal centers with cytolysis. In many cases there is extensive edema, associated with the cytolytic process.

"The crypts are often lined by columnar epithelium which is desquamated and often degenerative in character. There are islands of debris and particulate matter which are rather dense and homogeneous in staining reaction found in the epithelialized crypts.

"There is marked vascular congestion in all cases, and in some there is interstitial hemorrhage. The thickened vascular walls are markedly fibrosed and imbedded in connective tissue infiltrated by small round cells. The venous sinuses are distended. The endothelial lining is often definitely in a high state of mobilization, suggestive of a demand of unusual phagocytic proliferation. The changes occur chiefly in the vein, the walls, and in connective tissue supporting the veins."

DIAGNOSIS

The majority of people with infected tonsil stumps have very few complaints referrable to their throats. The infection seems to affect the entire body. They usually complain of feeling tired, loss of weight, joint pains, shooting pains down the arms and legs, and they frequently have bouts of fever. Others may have skin affections and eczemas. In some patients chronic sinusitis or chronic middle-ear disease is noted.

Repeated attacks of sore throat and enlargement of the cervical glands are the usual complaints in children. However, almost any unexplained systemic disease could be caused by the infected tonsil stumps.

The diagnosis is made by careful examination of the throat, by direct vision and use of a mirror. In cases which are usually considered clean tonsillectomies, a piece of tonsil tissue may be seen at the lower tonsillar pole, and it often merges into a hypertrophied and infected lingual tonsil. The lingual tonsil seems to hypertrophy after removal of the faucial tonsil. In some cases tonsil tissue is hidden by scars, although a certain fullness is seen at the inferior pole.

The diagnosis has been simplified by Dr. Otto Meyer,[9] of New York. His important signs are tenderness in the submaxillary region, over the tonsil stump and along the course of the jugular vein. These are always found in cases of tonsil stump infections and suggest that these may be the cause of a chronic, latent phlebitis of the jugular veins.

OPERATION

Before a definite date for surgery is made, we have a complete examination of the teeth and gums, including x-ray and tests for devitalized teeth, by an oral surgeon. It is our opinion that the results of surgery are better if infections of the teeth and gums are removed first.

Unless contraindicated, we use general anesthesia for all of our tonsillectomies because it lessens shock and provides complete relaxation, enabling the operator to perform better deep-throat surgery. We prefer to have the reflexes return as soon as possible after surgery and therefore prescribe no preoperative medication.

It is impossible to remove tonsil stumps and lingual tonsils in a gagging, uncooperative patient under local anesthesia. General anesthesia for all tonsillectomies is recommended by Dr. J. D. Kelly[4] and also by Dr. Alvin Street, of New York's Manhattan Eye and Ear Hospital. We feel that with the patient completely relaxed good vision of the entire throat is obtainable, and we may then work methodically, completely removing the entire mass of lymphoid tissue on each side.

We are indebted to Dr. A. A. Street for his technic in removing the tonsil stump and lingual tonsils, which is as follows:

The tonsil stump is grasped by heavy, curved forceps. The assistant or anesthetist holds the tongue so as to put tension on the anterior pillar. A long-handled Bard-Parker knife with a No. 12 curved blade is used for the dissection. The dissection is started at the junction of the anterior pillar and the tongue and is carried upward until the superior portion of the tissue is freed from the tonsillar fossae. After freeing the upper portion the blade is turned downward and the incision is carried down to the point where the posterior pillar merges into the pharynx.

The second step is to loosen the tissue from the pharyngeal muscle. This is done with the Carney-Fisher knife, which is curved with a saw-type cutting surface on its convexity. By gently stroking downward the adhesions and fibers of the tonsillopharyngeus muscle are freed from the tonsil tissue. Gentle traction is always maintained on the stump while the dissection is carried on.

It is important to carry the dissection down through the inferior tonsillar tissue, and then over onto the tongue and under the lingual tonsil. Thus, the dissection follows a definite fascial plane and tonsil stump and lingual tonsil can all be removed in one piece. We frequently expose the lingual branch of the glossopharyngeal nerve as it travels over onto the tongue. Care must be taken not to injure the nerve, or there may be a loss of taste in the posterior one-third of the tongue.

[9] Meyer, Otto: The Mechanism of Oral Focal Infection in Arthritis, *Medical Record*, **158**:604-606, (Oct.) 1945.

After the stump is completely freed from the muscle tissue it may be removed by a snare. Any bleeding vessels are grapsed by hemostatic forceps and ligated, which lessens post-operative hemorrhage. A careful inspection of the cavities is made in order to discover tags or bleeding before the patient is returned from the surgery.

We have had no serious complications in our series of operations for the removal of the lingual tonsils and tonsil stumps. A few patients have had temporary loss of taste. Occasionally we find an adhesion binding the tongue to the anterior pillar causing the patient some discomfort, such as difficulty in swallowing, reflex pain to the ear, et cetera. These adhesions may be satisfactorily relieved by cutting the bands with surgical diathermy.

CASE REPORTS

1. Mrs. M. E. B., aged forty-eight, a registered nurse, was first seen by us the last part of January. She was suffering from arthritis and also had a phlebitis of the legs which had kept her confined to bed. Her past history revealed that she had had a previous tonsillectomy at an early age. She had sought relief at various spas and clinics, but the relief received was only temporary. Her teeth and gums had been examined by an oral surgeon, but no evidence of infection was found. Examination of her throat revealed small infected tonsil stumps as well as very large, red, lingual tonsils. She was extremely tender over both submaxillary regions and jugular veins.

On February 7, 1945, a secondary tonsillectomy was done at the Methodist Hospital. Since then she has responded to treatments, and her arthritis and phlebitis have completely disappeared. She now works every day and is in good health.

2. Miss R. A., aged thirty-three, was seen by us in order to determine a possible cause for her peptic ulcer. She had had a previous tonsillectomy. Examination on February 24, 1945, revealed large tonsil stumps and lingual tonsils. There was marked tenderness in the submaxillary region and over both jugular veins. Her teeth were perfect.

A secondary tonsillectomy was done on April 14, at St. Vincent's Hospital. Two months after the operation her ulcer had disappeared and she no longer complained of any abdominal pain. She also had gained ten pounds, and said that she felt better than she had for years.

3. Mrs. M. S., aged forty-eight, was referred to us because of a right trifacial neuralgia. Her teeth and tonsils had been removed. She had been advised to have the fifth nerve sectioned. Examination on May 1, 1945, revealed large tonsil stumps. There was marked tenderness, especially over the right submaxillary region and jugular vein. On May 2 her tonsil stumps and lingual tonsils were removed at St. Vincent's Hospital. She has had no attack of facial pain since the operation.

4. Miss M. J. B., aged twenty-four, was first seen by us on April 20, 1945. She had a severe eczema and exfoliative dermatitis of both ears, which had been present for five years. Her teeth and tonsils had been removed. She had been seen by many physicians and had undergone allergy tests, x-ray treatments, and various forms of local treatment, with no improvement.

Examination revealed that her ears were covered with crusts and a purulent exudate. Her throat contained very large tonsil stumps. There was much tenderness over the stumps, the submaxillary region, and the jugular veins.

On June 18 the stumps were removed at the Methodist Hospital. Since then she has responded to treatment and has gradually improved. When last seen in August, the ears were completely healed.

5. Miss G. B., aged eleven, was seen by us on August 3, 1945. She gave a history of having had meningitis in May, 1945. She was left with a weakness of her right arm and leg. Her tonsils had been removed at the age of seven.

Examination revealed extremely large, red tonsil stumps. There was marked submaxillary and jugular tenderness, especially on the left. On August 23 her tonsil stumps were removed at the Methodist Hospital. After this she gradually improved, and three weeks after the operation the weakness had disappeared and she had gained twelve pounds.

6. Mrs. L. P., aged forty-eight. She was seen by us on October 30 at the Methodist Hospital. At that time she was having severe headaches and pain in the back of her neck and in her right hip. She had undergone three tonsillectomies. Her teeth had been x-rayed and no infection was found. Examination revealed masses of tissue at the lower tonsillar pole. These were extremely tender on pressure. There was marked tenderness over the submaxillary region and jugular vein. She was given a course of penicillin therapy, and on November 5 her tonsil stumps and lingual tonsils were removed. When last seen on February 8, 1946, she was symptom-free and was feeling better than she had for years.

CONCLUSIONS

1. Three-fourths of the patients who have had tonsillectomies have infected tonsil stumps.

2. These tonsil stumps and lingual tonsils may be the cause of systemic disease.

3. Infected tonsil stumps can be diagnosed by tenderness in the submaxillary region, over the jugular vein, and on pressure over the scar tissue in the tonsillar fossa.

4. Dr. Street's technic of tonsillectomy lessens any possibility of tonsil stumps or tissue remaining after surgery.

5. Much relief can be promised patients with symptoms resulting from tonsil stump infection by complete removal of the tissue.

224 N. Meridian Street, No. 301,
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THE MENTAL HOSPITAL OF THE FUTURE

M. F. DAUBENHEYER, M.D.*
BUTLERVILLE

The human brain, like all other substance, is composed of a combination of elements, these elements ultimately of atoms. These atoms contain, as all atoms do, stored-up energy. The union or combination of the different elements which form brain substance, particularly the gray matter, are so constituted that these atoms in a live brain generate a form of energy which is so far as man knows generated nowhere else except in live brain substance, and that energy is thought. Thought is a form of energy, radiated into space from the atoms in the live brain, and travels at the same speed as light or electricity. Not only do these atoms of the different elements composing brain substance possess the property of generating thought energy, but they also produce and radiate another form of energy, emotional energy, love, hate, jealousy, grief, and other forms of emotion. Emotional energy is radiated into space and travels at the same speed as thought energy, electricity, or light.

It is logical to presume that a brain, similar to a receiving set, one in harmony or tune with a brain generating and radiating thought or emotion might pick up those thought rays or emotional rays radiated into space although the two brains be a far distance apart.

In future years when science has unraveled the mysteries of thought energy and emotional energy, telepathy may become a reality.

The property possessed by the atoms composing brain substance, the property of generating and radiating thought energy and emotional energy is possessed only in live brain tissue; life is the essential stimulant, and when death comes and life ends, then no longer is thought and emotional energy generated; dissolution occurs and the elements again become material.

Man partook of the tree of knowledge, and, having done so, in science he can explore the mysteries of the heavens; break up and explore the atom—and there is no limit except that mysterious thing "life" which impels the atoms in live brain substance to generate thought, emotion, and judgment. Man did not partake of the tree of life; it is securely guarded, and it is futile and a vain hope that he will ever understand or know life.

Ideas and thoughts generated by the atoms in live brain substance causes the one possessing that brain to realize, to become conscious—conscious of self, of others, and of surroundings; in other words, oriented as to time, person, and place. From the ideas and thoughts generated the person thinks, reasons, forms judgment, acts, and becomes a free moral agent, a human being.

The ability to form decision and judgment constitutes that faculty of the mind known as will. Judgment, the same as thought energy and emotional energy, is a form of energy radiated into space with the same rate of speed as the others.

Thought energy, emotional energy, and judgment energy generated by the atoms in live brain substance, all blended together, constitute in the one possessing that brain, personality, individuality—man, the image of his Creator, "The noblest part of the work of God." When death comes, the brain substances dissolve into dust, but that personality which bears the nearest resemblance to that All Omnipotent Power which pervades all nature can never die.

From time immemorial the number "three" has been regarded as a sacred number—so regarded because that number referred to Deity. Deity was regarded as a triad being, "Wisdom, Strength, and Beauty." Wisdom, Allwise, Intelligence; Strength, the will; and Beauty, the emotions, love. These three, intelligence, will, and love, combined in one constitutes the Supreme Ruler of Heaven and Earth.

That super giant star, Antares, 400,000,000 miles in diameter, occupying 90,000,000 times as much space as the sun occupies, generating heat energy, light energy, and different ray energies from the breaking up of atoms in its heated interior, yet that immense mass can not do what a live brain in one human skull can do—generate thought, emotional and judgment energy. It can not think, love, and act; man can. Antares is only a vast mass.

Of all the generated rays, light, heat, electricity, cosmos, x-rays, and others which permeate cosmos and travel space, the all-important rays are the ones generated and radiated from the human brain-thought, judgment and emotional rays, and of these three the emotional rays, love, is in all probability the one which more than all others control the universe and is least understood by man.

The atoms of the different elements which form brain substances contain, like all atoms do, stored-up energy and are continually active, radiating thought energy and emotional energy. The thoughts generated may be inconsequential, silly, obscene, sexual, or of lightest or deepest logic and reason. The emotional energy released may be love, hate, jealousy, anger, remorse, sorrow, joy, or other forms of emotion.

Only a fractional part of the stored-up energy imprisoned in the atom is ever released. The amount expended varies in different individuals. In some the energy released may be sufficient to develop a Socrates, a Bacon, or a Shakespeare, while in others only a minimum of energy is released, and such a one is a gibbering idiot.

In certain brains a disturbance of the atoms has occurred, and while these atoms are active,

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radiating thought energy, yet those thoughts are disconnected, illogical, and delusional; and such a one has delusions, illusions, and hallucinations, and is not rational but insane.

Years ago, when a boy, I was thrilled when I read the fantastic tales of *Arabian Nights, Twenty Thousand Leagues Under the Sea,* and other such stories. In the short span of my life modern science has made these fantastic stories very commonplace with the auto, the airplane, the radio, the radar, the submarine, the refrigerator, the electric stove, and countless other marvelous inventions, even to the breaking up of the atom and releasing its energy.

The end has not been reached and more startling discoveries will be made. Scientists know that the atom can be changed, can be disturbed, and can be broken. Knowing this, I predict that the mental hospital of the future will not be a place of confinement and domiciliary care given to the unfortunate suffering from schizophrenia or other mental illness, or one mentally retarded, but instead the patient will go to the General Electric, Westinghouse, or other laboratory equipped with powerful electrical or other devices understood by the scientist, where he will receive treatment.

In those mentally retarded, classed as imbeciles and morons, the atoms in their brain substance will be shocked, disturbed, or parts broken off, and the activity of the atom increased to the extent that the feebleminded will then think, reason, and become intelligent human beings.

The insane, likewise, will receive similar treatment. The atom generating illogical thoughts will be shocked, disturbed by the giant electrical machine to the extent that once again the thoughts and emotions generated by the atoms will be rational.

ABSTRACTS

TOO GENERAL USE OF PENICILLIN CAUSES SKIN REACTIONS

Numerous people indiscriminately using penicillin ointment mixtures report suffering from skin inflammation, according to three Cincinnati physicians, who add that "with increasing use of penicillin, reactions may become even more frequent."

The physicians, writing in the June 13 issue of *The Journal of the American Medical Association,* are Leon Goldman, Forman Friend, and Lester M. Mason, all from the Department of Dermatology and Syphilology of the University of Cincinnati College of Medicine.

Although reports by many investigators have been presented on reactions to penicillin, the authors state that "our interest concerns chiefly the contact irritations from topical applications of penicillin in ointment mixtures."

With this in mind, the doctors made a study of approximately 350 patients with various type of skin lesions and found that sixteen reacted to contact with penicillin by developing a skin inflammation, thirteen of whom are here reported. The article points out that "although penicillin ointment was used all over the body and even in the mouth . . . , facial lesions seemed predisposed to the development of a dermatitis in spite of the fact that lesions of this area were not the most frequent lesions treated."

Approximately thirty-two male patients with acute infections of the face caused by micro-organisms were treated with penicillin ointment, and of those patients nine developed a contact dermatitis. Approximately eight female patients with varying types of this same infection on the face and neck were treated with penicillin ointment and three developed a dermatitis. The authors state that their study suggests caution in the use of penicillin ointments in facial infections, especially in the male. One other contact dermatitis due to penicillin ointment was found on the legs of a patient.

The article reveals that reactions to penicillin ointments are manifested in several different forms, such as skin rash, measle-like eruptions with scaling of the skin, or the eczematous type with inflammatory skin disease, lesions and a watery discharge.

"In our present state of knowledge regarding the causes of penicillin dermatits," the authors write, "not too much practical advice can be given regarding prophylaxis except to use penicillin only where and when indicated . . . for superficial topical therapy and not indiscriminately for everything."

DRUG AIDS PATIENTS SUFFERING FROM ACUTE VENOUS THROMBOSIS

A Swedish physician's five-year study reveals that patients suffering from acute venous thrombosis can be spared pain, ulcers, and even death, by treatment with heparin, one of the drugs which prevents blood clotting.

Gunnar Bauer, M.D., surgeon in chief of the General Hospital in Mariestad, Sweden, presents his report in the May 18 issue of *The Journal of the American Medical Association.*

Between October 1, 1940, and September 30, 1945, 209 cases of acute thrombosis of the deep veins of the leg were treated at the Mariestad Hospital. As a result of heparin treatment, pain, fever and swelling were eliminated; the average period in bed was shortened from 40 days to about 4.7 days; the death rate was reduced to less than one-tenth of what it was before.

The author reviewed a series of 264 patients with thrombosis treated by accepted methods over a ten-year period and found that forty-seven died. In the heparin-treated group, covering a five-year period, only three died.

Dr. Bauer made an intensive study to prove his theory that the starting point of the clotting process was in the lower part of the leg. X-ray diagnosis, used on 190 patients, showed in over 98 per cent various phases of evolution of the clot in this region.

The author suggested that this knowledge should be an important aid in diagnosing the disease in its early stage. Whenever there is a rise in temperature without any obvious reason, or a pain or stitch in one side of the chest, the lower part of the patient's leg should be immediately examined. X-rays are the only way to confirm the diagnosis. However, if swelling and blueness of the skin are present it indicates that the disease is in an advanced stage and unfortunately it is then often too late for treatment.

One of the unpleasant after-effects of this disease has always been ulcers of the leg. Dr. Bauer states that from 80 to 90 per cent of leg ulcers which are thought to be due to varicose veins are really caused by an earlier deep thrombosis. Heparin treatment clears up the infection in a few days and eliminates such painful and incapacitating developments in the future.

The author summarizes his suggested method of treatment in four steps: "(1) early diagnosis; (2) immediate intensive heparinization (by injection into the veins); (3) movements of the leg from the beginning; and (4), getting the patient out of bed the moment the acute thrombosis symptoms disappear, before the termination of heparin injections."

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AUGUST, 1946

Editorials

LONGEVITY AND GERIATRICS

For many years we have been hearing a lot about longevity; how many years of life expectancy had been added to the old figure of 1850, at which time the new-born babe might confidently expect to live to the age of forty, whereas ninety years later that figure had been extended to sixty-three. There has been a lot of talk and so much written on the subject that most everyone knows about it.

Now something new has been added—yet not exactly new, since a book on the subject was published in 1914—the subject being "Geriatrics." The American Geriatrics Society was organized in 1941, and the first magazine to be devoted to the subject was published on January first of this year.

As is usually the case when something new or some new problem arises, Indiana stepped right out to see what it was all about. A meeting was arranged in Hurty Hall, Indianapolis, and a group of eminent speakers appeared on the program, which attracted unusual interest not only in the medical profession, but in the lay press. We are happy to state that practically all these papers will appear in later issues of THE JOURNAL; the speakers have been contacted, and each one has replied enthusiastically.

The Indiana State Board of Health, recognizing the importance of the geriatrics problem, recently created a new Department of Geriatrics, with Dr. William F. King as director, a selection that has met with general approval. Doctor King has prepared an outline to cover the matter, and as time goes on he will add materially to the present program.

"Life Begins at Forty" was the title of a book which came out a few years ago, and which met with a generous response from the reading public. Many quips resulted from the reading of the book, but it seems that the reading public soon was aroused to a sense of the importance of having reached the age of forty.

As we understand it, the program in geriatrics is not so much to further lengthen the life of those who have reached the three-score-and-ten period, as to make their future years more comfortable. In order to bring this about there must be periodical examinations of these people, a thing just as important as the periodical examination of the younger group.

It has been said that "preventive geriatrics is personal; it must be individualized; it must be applied continuously; and it must be applied long before actual disease has become manifest. Just as preventive pediatrics seeks to safeguard well children and make them healthier and stronger for maturity, so preventive geriatrics must seek to make men and women healthier and stronger in advancing age."

It is believed that this build-up against the advent of old age should be undertaken between the ages of forty and sixty. However, the men and women of forty usually scoff at the idea that they are adding years to their age; and even when they have approached the sixty mark most of them continue to "have young ideas" and give little thought to the fact that, after all, they are getting "a wee bit old."

Our problem seems to be to convince these groups that now more than at any other time in their life they need medical guidance, periodic examinations, and revamping of many of their habits, et cetera. We daily see examples of men and women well above the age of seventy getting about very well and seemingly possessed of all their normal faculties; on the other hand, we see too many in the sixty-year bracket who do not have the vim and vigor that normally should be theirs.

This geriatric problem has become a big job for the medical profession, and the sooner we recognize it and do something about it, the earlier will we accomplish the task before us.

DEAN GATCH RESIGNS

Willis D. Gatch, for more than thirty-four years connected with the Indiana University School of Medicine, the latter half of that period serving as its dean, has retired as of July first. Until his successor has officially been appointed, the affairs of the medical school will be directed by a committee of four, named by President Wells. This committee consists of the following, all department heads of the school: Drs. John D. VanNuys, medical director of the Medical Center; J. O. Ritchey, head of the Department of Medicine; Matthew Winters, head of the Department of Pediatrics; and Frank Forry, head of the Department of Pathology.

The resignation of Dean Gatch comes as a distinct surprise to most of us. Last November, during the French Lick convention, we spent an hour with him one evening, during which time he went into detail as to his future plans for the Medical Center, leaving us to believe that he planned to continue in his present capacity until he reached the retirement age some two years hence.

Doctor Gatch is Hoosier-born, the son of an Aurora farmer; two of his uncles had served as medical officers in the Civil War, thus giving him somewhat of a medical background. He graduated from Indiana University in 1901, and six years later took his medical degree at Johns Hopkins. For some four years following this he served as assistant resident surgeon at the Johns Hopkins Hospital, later serving as chief resident surgeon at the Washington University Hospital, in St. Louis. He then was named the head of the Department of Surgery at the Indiana University School of Medicine, later becoming its dean.

There is universal regret that Doctor Gatch has found it necessary to give up the duties which he has performed so well, over a long span of years; but, as he says, "I have been there a long time; I believe I have done my duty toward the school." And he has done a good job of it. Our medical school stands well at the top of the list of teaching institutions, much of its success being due to the activities of Dean Gatch.

We know of no medical school in which the dean held a higher opinion of his faculty than Doctor Gatch. In conversation with him the subject of the school came up several times, and each time he remarked, "I have a *good* faculty, the most loyal group that a man could have." During the war period he was hard put to it to keep things going as he wished them to go—without any letdown in the high quality of teaching—and his faculty loyally stood by him for almost five years, keeping the school going, with no thought of vacation or self-preservation.

The dean is a natural teacher, whether it be in the class room, the clinic, or when speaking before medical groups. He is an eminent writer on medical subjects, a clear thinker who holds the attention of every reader.

We deeply regret that Dean Gatch is leaving the Medical Center, but, after all, thirty-four years is a long stretch on one job, and, nearing the "Biblical Age," it is little wonder that he feels he is entitled to some surcease from the long years of planning and seeing that the plans were carried to completion.

In his letter of resignation the dean did not overlook certain recommendations, matters in which he has been interested for many years. One of his most cherished ideas is given due prominence in that letter, the bringing of the first medical year to the Indianapolis campus, a plan that meets with the approval of most Indiana physicians. A second recommendation is that direct control of the medical school be placed in the hands of physicians, which suggestion is also universally approved by Hoosier Medicine.

THE JOURNAL, regretting as we all do that the dean finds it advisable to spend a few years "on his own," wishes for him a most pleasant "vacation," although we know just what the man will do —he will give his entire time to private practice, working indefatigably as long as he can. We wish the best of everything for a man who has done so much for his beloved profession.

"SOLO OR SYMPHONY"

Thus is the title of a brochure sent out by the Medical Group Practice Council of New York City, referring, of course, to the best course for a medical man just out of service to pursue: Shall he enter private practice as an individual, or shall he join with a group of physicians? That problem, to our personal knowledge, has become one of the foremost of the time.

Much of the quandary in which the former medical officer finds himself is due to the fact that his Army or Navy career, for the most part, has been such that he was but a part of a group of physicians, each having his particular field to supervise and manage. Now that he has returned home and is ready again to enter the practice of the healing arts, it is but natural that these things will have to be worked out, each as an individual case.

Then, too, his first year or two of practice have been of the group sort, since as an intern he was but a part of a very large "group practice," in the hospital in which he was employed.

There can be no question but that these groups have done much to raise professional standards and that they have increased the quality of service. It is stated that of the more than six hundred groups now operating in this country, the greater part of them were organized between the years 1918 and 1930, post World War I years, if you please. Now thousands of service men are contemplating entering into an already-organized group or forming a new group.

In another column we have mentioned the plan adopted by an Evansville group, connected with

a local hospital. The 70,000 medical men, more or less recently returned from service, have done and are doing a lot of thinking about these matters. Many of the younger group have decided to take a residency for one, two, or three years, looking toward the entering of a specialty.

In this connection it is well to remember that entering a specialty now involves far more than simply deciding so to do; there is the matter of certification that must be attended to. In these days practically every specialty has its "Board," and properly so.

The booklet referred to, "Solo or Symphony," is made up of letters written by returned service men, chiefly to members of the Group Practice Council, and are, therefore, of the rather intimate sort—speaking right out loud and saying just what the writer believed to be true. In one of the letters the writer directs attention to the fact that group practice is a gain not only in efficiency but in the matter of economy.

Ten men each conducting a private office, each office modernly equipped, some with a trained nurse in charge, would result in an unusually large overhead. The same ten men, formed into a group, would be able to cut the overhead to a respectable figure, plus enjoy many other advantages.

We do not mean to infer that the private practice of medicine should be abolished—far from that; but there are many instances in which the formation of a group will work out most satisfactorily.

"SERENDIPITY"

While we never have been in any sense an etymologist, we always have been interested in words new to us, and have spent some time, with a smattering knowledge of Latin and Greek, in trying to analyze the word and sense its meaning ere rushing to Webster.

Some years ago an article in one of our medical journals was written by Dr. John Blank, "helcologist" to some hospital or another. Never having heard of that specialty, we mulled over it for some months, finally seeking the dictionary, where we learned that a helcologist was an ulcer specialist.

A few days ago we picked up the June number of The *Journal of the Alabama State Medical Association*, and right there on the index page was a new word, the word heading this editorial. We have to admit that the word stopped us; for some little time we thought about it, getting nowhere. Again calling on Webster—late edition—we learned that it means "the ability of finding valuable things unexpectedly," and that is just what this article in the Alabama magazine is about.

The paper was prepared by Dr. Alton Ochsner, of the Department of Surgery, School of Medicine, Tulane University, and the Section on Surgery, Ochsner Clinic, New Orleans, and presented as the "Jerome Cochran Lecture" before the annual meeting of the Alabama State Medical Association, at its meeting of April seventeenth.

Dr. Ochsner tells of his first acquaintance with the word "serendipity," finding that it was coined in 1754, by Horace Walpole; hence, it seems to have been forgotten all these years, until recently resurrected.

We agree with the writer in his declaration, "No reading is more stimulating than stories of accidental discoveries and their influence upon medical science." For years we have read of many such incidents, all of which have been fascinating to us, but we never got around to making a list of such accidental discoveries. Dr. Ochsner, however, seems to have delved deeply into this somewhat rather unexplored field and come up with a vast fund of worth-while knowledge.

He speaks of the writings of Hippocrates, Archimedes, Pythagoras, all of which teem with mention of these accidentally-discovered things. He cites the observations of James Watt, sitting in his mother's kitchen and noting the rise and fall of the lid of a steaming kettle, and of that of Isaac Newton, wondering why the apple fell "down."

Getting into the medical field, he cites the accidental discovery of Ambroise Pare, who, when the hot oil commonly used in the treatment of battle wounds was not immediately available, had to use a makeshift external dressing, discovering that this was "just the thing." Again, the use of a preparation made from "foxglove," which we now know as digitalis, by a group of farmers in the home treatment of "dropsy" finally led to the discovery of the important fact that this ailment was directly connected with a heart ailment.

The discovery of the stethoscopic principle was accidentally made by a young French physician who had to devise some method of listening to the chest of a "robust young woman who was in great distress with heart trouble."

Many of the steps in the discovery of vaccination against smallpox, by Edward Jenner, were accidentally detected, and it was only through his native ability to follow up these observations that he finally made his history-making discovery.

The more than thirty thousand dyes now made from coal tar were definitely the result of an accidental discovery, 'way back in 1856. And from this source we now derive many useful drugs.

Pasteur had many accidental discoveries to his credit, as did John Hunter, who made his first experiment by ligating the carotid artery of a deer, later discovering that collateral circulation had been established.

"The use of ethylene as an anesthetic was largely the result of accidental observation," states the author, as was the discovery of the relation of pancreatic disease and diabetes. The roentgen ray was discovered by accident, which is true of many of the commonly-accepted theories and treatments in universal use today.

Serendipity is not by any means a lost art; every

day some member of the medical profession makes an accidental discovery, many of which never are reported. We dare say that every reader of this article has made some accidental discoveries in the field of medicine, thus becoming, unknowingly, "serendipidiats!" Some of these discoveries have been made known and are in general use; others have not received any publicity, hence, are used only by the discoverer.

The recognition of these accidental discoveries is the important thing; were it not for the ability to observe things, on the part of those who have made these important discoveries, they would not have been recognized and invaluable information would have been lost or overlooked. Thus the subject of "serendipity" is most interesting, and we are deeply indebted to Dr. Ochsner for bringing so many important considerations to our attention.

POSTWAR RACKETEERING

A meeting was held in New York City on January ninth which should have the attention of practically every resident of our country, since it directly affects all of us. The title given to the gathering was "Conference for Safeguarding Wartime Savings," the chairman being Mr. R. R. Deupree, president of Procter and Gamble, of Cincinnati. The roll of those attending this meeting reads like the "*Who's Who in American Business.*"

It was stated at this meeting that at the close of World War II there were in the hands of American investors, referring to the "little fellow," some sixty-four billions in federal securities, fifty-four billions in savings accounts, and sixty-three billions in currency and checking accounts. The declaration was also made that a sizeable portion of this one hundred eighty-one billion dollars "may be drained into uneconomic and illegitimate channels by gyp schemes, rackets, and unfair practices."

There is, of course, nothing really new about these findings. The same thing has happened after World War I, and after every great war. We had some folk who had been provident, laying aside savings, buying federal securities and putting them away for future use; and we had the same horde of Harpies besetting us, seeking to take from us what we had saved—and in many instances they did a right smart job of it. Stocks, bonds, and real estate seemed to be the favorite means used by these gyp artists. President Truman sent a message to the meeting in which he said, "The Federal Government is, indeed, happy to join with other groups as a partner in this enterprise."

The Better Business Bureaus of the country also have enrolled and will give their every effort to further the plans being adopted, to avert such a calamity as followed World War I. The American Newspaper Publishers Association has declared that they will go all-out for the program; the banks of the country are "for" it, and the Securities and Exchange Commission is prepared to lend invaluable assistance. Hence, it would seem that the people behind the movement are really serious about it, and they might well be so.

Right after World War I "stock salesmen and promotors" appeared overnight. New "companies" were organized; the lithograph trade was swamped with orders for ornate pieces of paper, declaring that the owner thereof was a stockholder in "Bunkum, Hocus-Pocus and Company." Most of us are familiar with what went on at that time, and how soon people's savings disappeared.

Billions of dollars in savings, Liberty Bonds, and other securities, all of which were affording the owners a fair income, were sacrificed in buying these worthless pieces of paper; and the "market" having been exhausted in a few years the gyp artists went undercover, having accomplished their purpose.

Meanwhile, some of our medical friends proved not to be immune to the importunities of these slick artists; they bought the baubles and trinkets like mad, just as did other folk. We cannot refrain from again relating an experience we had when returning from New York, along about that time, when we met up with a chap in a Pullman smoking-compartment. During the course of our conversation he confided that he was a salesman and promotor, just getting out of business; that his market was just about cleaned up. He did not know as to my profession, which made his next statement all the more interesting. He said, "You know, I've been in this racket for several years now, and have sold the most impossible bonds, stocks, et cetera, and my easiest marks are the doctors, with the lawyers a very close second! Members of both these professions are suckers to the highest degree."

One of the figures about whom we will hear much as this campaign goes on is a chap who likes to be known as Tom Clark, the Attorney General of the United States. In a news-story from Washington, under date of March 17, Clark stated that his department is making a real investigation of many of these frauds, giving special attention to real estate promoters and the small-loan sharks. He makes the statement that "usurious money lenders" are at it again, charging the high, illegal rates that some years ago utterly confounded many who borrowed money from some of these outfits. For some years past, due to a concerted campaign to control these evils, little has been heard regarding overcharges by some of these loan companies, but it now appears that with the return of service men, each with a few hundred dollars "discharge money," there has been a revival of some of these sharp practices.

Tom Clark avers that he has reason to believe that some real estate operators are pulling some "funny stuff" on ex-service men, in that they are putting "extra charges" on sales of real estate. These boys, most of them, have been away from

home and away from civilian life for many years. They are glad to get back. They want to re-establish their own homes, and will jump at most any offer that is put before them. There is, of course, a housing shortage—in passing, we wonder why the Federal Administration is so slow in remedying this, and the returning veterans, many of them bringing wives and children from other nations, are eager to find a place to call "home." They may have forgotten that there is an organization of "realtors"; most every community has them, and, in general, dealing with members of this organization is a very safe procedure. But there also are "real estate sharks," too many of them. In our home community we have had too frequent examples of the workings of these vampires; they come from out-of-town—very frequently from out-of-state—and acquire a tract of land which is subdivided and placed on the market with much hullabaloo. They build "homes" for the suckers, and not until they have moved in do they find that novel methods were used in construction; that sewage connections are one of the great problems; and that there simply is no surface drainage. We recall one such subdivision which after a heavy rainfall called for rubber boots, and even boats to get about the community. Septic tanks regularly overflowed, adding much to the general confusion and to the health perils of that community. Every city of any size has such problems, and it now seems that there is more than a plethora of them, due to the fact that most folk have a little money laid aside, and it is the job of these promoters to get that money, by hook or crook—usually by crook.

The proposed plan to help people save their dollars is being widely publicized. It has the backing of all decent-thinking people, and, we believe, will succeed in saving the money of thousands of people. However, we must continually be on guard, not alone for ourselves but for our friends and neighbors. Doctors can do much to help in this campaign, first by ceasing to be suckers themselves, and next by talking with their patients about the matter, since very commonly patients discuss such affairs with the family doctor.

It is a big job, one that will require the assistance of everyone concerned with the economic affairs of the postwar period; we have our place in the program, and it is up to us to do our part.

MAKE HOTEL RESERVATIONS NOW!

If you have not already made your hotel reservation, by all means do so at once. Rooms will be at a premium, and, come October, it might be well to have a roof over your head, and no one wants to miss the annual meeting of the Indiana State Medical Association, at Indianapolis, October 29, 30, and 31, 1946.

Editorial Notes

The following communication received from the Food and Drug Administration is self-explanatory and warrants attention:

"It has come to our attention that the sales representatives of some penicillin manufacturers have informed druggists that penicillin troches may be sold over the counter without a prescription. It is our view that under the provisions of section 146.4 (b) (6) of the penicillin regulations the over-counter sale without a prescription of any form of oral penicillin now being certified violates section 301(k) of the Federal Food, Drug, and Cosmetic Act. We will appreciate it if you will make this view known to those sales representatives who may be advising druggists otherwise."

The Committee on Revision of the *Pharmacopeia of the United States*, after a long period of hyper activity, has announced that this volume will be ready for distribution along in November of this year, and that as of April 1, 1947, it will become "official." This huge undertaking has occupied the time and the attention of the committee for many months and will be a distinct addition to our knowledge of therapy.

The newer drugs, especially the chemotherapy group, has received much attention and will be formally listed in the new edition. Several changes in nomenclature are being made, an example of this being ergot, which now will be listed as ergonovine and ergotamine. The committee has published a list of recent additions to the book, covering many of the newer drugs as well as several which heretofore had not been included.

We finally have gotten around to a comment on the appointment of Dr. William Niles Wishard, Jr., as a member of the State Medical Board. This brings up some thoughts regarding the early days of official "Medical Boards" in Indiana. It was in 1897 that Dr. William Niles Wishard, Sr., long-time head of the Legislative Committee of the Indiana State Medical Association, drew up what we now term as the basic medical law of the state, and was instrumental in having the bill enacted into a law. With a few amendments since that time, the law still stands as a monument to the "Grand Old Man of Indiana Medicine," and it is fitting that his son, after these long years, should have to do with the enforcing of the law. In 1927, when the drugless amendment was passed, while in conversation with Doctor Wishard, Sr., commenting on the new amendment, he remarked, "I like the injunction feature of this amendment; I don't see how I overlooked that—we could have put it in and had it passed just as easily."

Dr. William M. Mills, for eleven years editor of *The Journal of the Kansas Medical Society*, has recently resigned, after having been elected president of the parent organization. Dr. Lucien R. Pyle, of Topeka, has been named as his successor. Dr. Mills, during his rather long service in an editorial capacity, did much to make the Kansas publication one of the best of the smaller group of magazines. Possessed of an intimate knowledge of medical organization, particularly in his home state, he was able to cope with the many problems continually arising. His successor has recently finished a four-year service in the Navy, during which time he did editorial work in addition to his other duties; hence, the new job is not entirely new to him, and we wish him success in his new role.

Henry Schuman, well known as the publisher of books relating to scientific medicine and medical history, announces an expanded program for the near future. His work, "A Bio-Biography of Andreas Vesalius," written by the late Dr. Harvey Cushing, is perhaps the greatest of all such volumes. This was an extremely limited edition, and already, after but three years, the book is in great demand. At the time the book was published Dr. Morris Fishbein remarked to the writer, "after about twenty years this book will command a price of fifty dollars or more." Lovers of such medical literature will do well to be on the lookout for a new volume, to be published in October, honoring Drs. William T. G. Morton, discoverer of anesthesia; and Dr. John C. Warren, who performed the first operation under general anesthesia.

One of the unfortunate features attendant upon the bringing out of new drugs and new treatments is the avidity with which Mr. John Q. Public and his kith and kin try to "take over." In no time at all the public becomes interested in these drugs, such as the sulfas, penicillin, streptomycin, et cetera, and hie themselves to the nearest drug store to get the drug and do some personal "experimental medicine." This, of course, chiefly is due to the pronouncements published in our papers and magazines; it is good copy, from a news standpoint, and the American public long since has evinced a very high interest in what is new in medicine. Just what measures of control in such matters should be undertaken we do not know, but we do feel that there is too much self-drugging and too much activity in the matter of the newer therapy.

During the "shut-down" period of the Randolph County Hospital, mention of which was made last month, an emergency hospital was opened in the local Masonic Temple. The first emergency operation in the temporary hospital was performed soon after the opening, being an appendectomy. Ladies of the community volunteered to look after the cooking and the laundry of the emergency hospital. The Board of Trustees later announced that the county hospital would again be open early in July. It is hoped that the controversial features of the episode may be smoothed out and that the hospital again will come into its own as a necessary feature in that county.

The Bartholomew County Health Council, concerning which we have made some comment in the past, has not been very active in the past few months. Organized in 1943, primarily as a wartime health measure, the council probably felt that the need for its activities were not so great. However, there recently has been a demand that the council again become active, and a meeting was called for all interested in attending. This was one of the most active groups in Indiana, and we trust that ere now they have again become organized and are on the job. The council represents the local medical and dental societies, the county hospital, the county nurse department, the tuberculosis, cancer, and infantile paralysis chapters, as well as the health department of the City of Columbus.

According to reports, a group of Evansville physicians have organized The Welborn Hospital Clinic Association, an idea long studied by Dr. Mell B. Welborn. Twelve local physicians have formed into two groups, incorporating as non-profit organizations. The members of these groups will be paid yearly salaries, rather than being paid via the dividend route. This will include payments of salaries to nurses, technicians, et cetera, and what money is left at the end of each year will be put into a special fund to be used for research work and for the advancement of the healing arts in that community. This sounds a bit Utopian, yet we cannot see why such a plan is not workable; at least it seems perfectly feasible, and will no doubt be watched with much interest by many Indiana physicians. After all, the plan is largely molded from those in operation at the Mayo, Cleveland, and Lexington clinics, all of which are eminently successful.

Annual Session of the
INDIANA STATE MEDICAL ASSOCIATION
October 29, 30, and 31, 1946

President's Page

All branches of society, business, the professions, et cetera, have always been confronted with problems that were at times almost insurmountable, but they have always been solved, and the organization moves on. It cannot stand still, for if it did we would see signs of degeneration which in the end would be fatal to our way of life. The solution of many problems of life may not be solved to everyone's satisfaction; but even if our ideals are not always achieved, we must never give up. As long as our ideals are right they will sometime materialize, no matter what subversive measures may be thrown in the way.

American Medicine is composed of members of the medical profession, from the lowest to the highest, all individuals confronted with their own problems plus the problems of the medical organization, which at this time is also confronted with many puzzling situations in its fight for existence. I am firmly convinced that all the way from the first record of the science of treating disease there never have been greater problems facing the medical profession. If we were dealing from the dollar-and-cent basis alone, each individual would have a very easy time in solving these problems, but we are not. We are dealing with the welfare, both in sickness and in health, of all the citizens of this broad country of ours. Therefore, the task becomes more complex from day to day and year to year, and as our people become more enlightened, the demand becomes greater upon the individual physician, and in turn upon medical organizations.

American Medicine must not shirk its responsibilities at this stage; all personal animosities must be cast aside; it must get into the fight with coordinated action from everyone of us. One section of the country's medical organization cannot brand itself as the ultimate of perfection and demand for itself all the glory and all the favors by having, say, a better political pull, thereby setting up a poor standard of cooperation with other sections and adopting the old adage: "Either rule or ruin." This problem must be solved in other ways—by tolerance and unselfishness, allowing others to have a fair chance for growth, thereby placing all in a better position to cope with the evils that confront us.

Then, too, the personal equation has loomed large in American Medicine. Everyone agrees that all outstanding members should be honored when the tasks assigned to them are completed. Such recipients should give way to others who are equally as competent, and not attempt to monopolize such honors from year to year until dissension looms large, and the question begins to be formulated in the minds of other members just how to go about getting rid of such an individual. In countries with other forms of government, where the freedom of the individual is destroyed, those who wish to impose their services on others are taken out of the picture, usually by force. Of course, that must never happen in this country, whatever the organization may be. Would it not be better if all domineering organizations and individuals could see the sunset of their day, when in the evening, at the end of a useful and finished career, the beautiful words of the poet might be applicable: "Go not like the quarry slave at night, scourged to his dungeon, but like one who wraps the draperies of his couch about him and lies down to pleasant dreams."

J. E. Farrell

REPORT ON THE ACTIVITIES OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION AT THE SAN FRANCISCO MEETING, JULY 1 TO 4, 1946

DON F. CAMERON, M.D.

FORT WAYNE

The House of Delegates convened Monday morning in the Colonial Room of the St. Francis Hotel, at 10:00 A.M. About thirty of the one hundred seventy-five delegates were late in registering due to delayed trains and a local transportation strike. However, Indiana's four delegates, Drs. Crockett, Giordano, Hamer, and the writer were on time, as also was Dr. R. L. Sensenich, the president of the Board of Trustees. Indiana's Executive Secretary, Ray E. Smith, and Tom Hendricks, now on full-time duty with the A.M.A., were also present to complete our representation.

The first official act of the House was to choose the recipient of the Distinguished Service Award given annually in recognition of outstanding achievements in the Medical Sciences. This year the honor fell to Dr. Anton J. Carlson, the distinguished professor emeritus of Physiology at the University of Chicago.

Dr. Roger I. Lee, of Boston, President of the American Medical Association, gave an excellent forward-looking address, urging doctors to take an increasingly active part in public affairs. Likewise, our president-elect, Dr. Harrison H. Shoulders, of Nashville, addressed us in his usual forceful manner, urging again that we make available to all people high grade medical care at a cost within their reach and without the interposition of a governmental agency between the patient and his doctor. He also urged the extension of prepaid voluntary medical insurance plans by state societies. The speaker of the House, Dr. Roy W. Fouts, of Omaha, then set up the machinery by means of which the House is able to handle, in an efficient manner as a rule, the large grist of resolutions and proposed actions dumped into the hopper. The Speaker appoints a number of reference committees to whom these proposed actions are referred for further study and recommendations. Dr. Hamer was appointed on the Committee on Industrial Health, and the writer on the Committee on Hygiene and Public Health. Dr. F. S. Crockett, as chairman of the important Committee on Rural Medical Service, gave an excellent report on its organization and activities for the past year.

A great number of resolutions dealing with a wide variety of subjects connected with the practice of medicine and the general policies of our association, and with national legislation which might affect us, were presented to the House for appropriate action. A detailed report of the proceedings will appear in *The Journal of the American Medical Association*. A summary of the more important actions of the House follows:

It adopted a special resolution commending Dr. Ray Lyman Wilbur, who is retiring after twenty-four years of service as chairman of the Council on Medical Education and Hospitals.

It adopted a recommendation of the Board of Trustees requiring the House of Delegates to meet twice annually in view of the increasing business to be transacted. The second meeting will be held at the association's headquarters in December.

Special recognition will be given next year to the fact that it will be the hundredth anniversary of the founding of the A.M.A.

It adopted and made available to all members a report by the Council on Medical Service and Public Relations, outlining approved standards for Prepaid Voluntary Medical Insurance Plans.

The House adopted a resolution strongly recommending to Dr. Thomas Parran, chairman of the United States Committee on World Health of the United Nations Organization, that his committee restrict its activities to questions of communicable disease and public health and not get involved in discussions of the type and control of medical service rendered within the boundaries of member nations. This resolution was in response to definite information that Senator Murray and Dr. Parran were planning this extension of their work.

It adopted the report of the Reapportionment Committee, which will keep the membership of the House to 175. A few states will lose a delegate, and a like number will gain one. Indiana will continue to be entitled to four delegates.

A brief report on the Medical Corps of the Army and Navy during the war was given to the House by Major General Kirk and Vice Admiral McIntire. Each one commended highly the efficiency and skill of the civilian doctors during the war. Each one recognized and admitted that at times an oversupply of doctors was retained in the service, but emphasized that war is an extremely wasteful occupation.

The House approved the recommendation of the Secretary that county societies should be encouraged not only to build up membership, but also to urge as many members as possible to apply for fellowship.

The House approved enforcing as much as possible the rule that all proposed resolutions and recommendations should be sent to *The Journal* for printing at least sixty days in advance, so that the House and all members can have more time for their consideration.

In an executive session, Dr. Sensenich reported

that the Board of Trustees had employed the Raymond Rich Company to make an exhaustive survey of the whole organization of the American Medical Association with special attention as to how best to correlate its far-flung activities and advance its standing in public relations. The House adopted the recommendations, which in brief were:

1. Take a more active part in dramatizing and making known to the public the scientific advances in medicine.

2. Employ a top-flight economist to study and make recommendations on the overall picture of medical economics.

3. Employ the best public relations man obtainable to assist the general manager.

The adoption by the House of these recommendations served to appease more or less those whose chief activities of late have consisted of attempts to compel the Board of Trustees to restrict some of the activities of the editor of *The Journal*.

On Thursday afternoon the House adopted a resolution approving the establishment in state societies of a section on the General Practice of Medicine.

Officers elected for the coming year were: Olin West, president-elect; Edward L. Bortz, vice-president; George F. Lull, secretary; Josiah J. Moore, treasurer; and Roy W. Fouts, Speaker of the House.

Olin West was notified of his election, and in response made a very dramatic and moving extemporaneous address, which was applauded with such a show of enthusiasm and unanimity as has seldom been seen in the House. He emphasized the fact that it is each individual doctor in his daily work who is really the "spokesman" for the A.M.A., and he is also its most important public relations representative.

The next annual meeting of the American Medical Association will be held in Atlantic City, beginning June 9, 1947; the 1948 meeting will be held in St. Louis, beginning June 7; and New York City was chosen as the convention city for 1949.

INDIANA PHYSICIANS WHO REGISTERED AT A.M.A. MEETING IN SAN FRANCISCO, JULY 1-5, 1946

Arbogast, J. L., Indianapolis.
Barrow, John H., Dale.
Bickel, David A., South Bend.
Blackburn, Erwin, South Bend.
Blum, Leon L., Terre Haute.
Broomes, Edward L. C., East Chicago.
Bruetsch, W. L., Indianapolis.
Cameron, Don F., Fort Wayne.
Cartwright, E. L., Fort Wayne.
Catlett, M. B., Fort Wayne.
Clauser, E. H., Muncie.
Collins, J. N., Indianapolis.
Crockett, F. S., Lafayette.
Culbertson, C. G., Indianapolis.
Cure, Elmer T., Muncie.
Davis, Carl M., Valparaiso.
Dollens, Claude, Oolitic.
Donahue, George R., Lafayette.
Duemling, Werner W., Fort Wayne.
Duggan, James A., South Bend.
Dunn, F. W., Muncie.
Edlavitch, B. M., Fort Wayne.
Fish, C. M., South Bend.
Folz, Charles J., Evansville.
Fox, C. Phillip, Washington.
Frasch, M. G., Lafayette.
Gaddy, E. T., Indianapolis.
Garceau, George J., Indianapolis.
Gastineau, F. M., Indianapolis.
Gilbert, Ivan, Terre Haute.
Giordano, A. S., South Bend.
Gustafson, G. W., Indianapolis.
Hamer, H. G., Indianapolis.
Hamilton, E. E., Dayton.
Herzer, C. C., Evansville.
Hines, Don C., Indianapolis.
Huffman, V. Park, South Whitley.
Hughes, W. F., Indianapolis.
Irey, P. R., Plymouth.
Kamman, George H., Seymour.
Kamman, Herman H., Columbus.
Kohlstaedt, K. G., Indianapolis.
Koons, Karl M., Indianapolis.
Kraft, Bennett, Indianapolis.
Kuhn, Hedwig S., Hammond.
Linton, C. E., Medaryville.
Lord, Glenn C., Indianapolis.
McCaskey, C. H., Indianapolis.
McIlwain, Robert, Marion.
McKittrick, W. O., Washington.
Martin, Hugh E., Indianapolis.
Masters, Robert J., Indianapolis.
Maurer, J. F., Brazil.
Mehl, Rudolph A., Evansville.
Middleton, H. N., Indianapolis.
Mitchell, A. M., Terre Haute.
Montgomery, L. G., Muncie.
Myers, Roy V., Indianapolis.
Newland, A. E., Bedford.
Nickel, Allen C., Bluffton.
Norman, O. B., Indianapolis.
Osterman, L. H., Seymour.
Parker, George F., Greencastle.
Pearson, Lyman R., Indianapolis.
Petronella, Samuel J., East Chicago.
Rice, Thurman B., Indianapolis.
Rissing, Walter J., Fort Wayne.
Ruth, Martin L., Indianapolis.
Sensenich, R. L., South Bend.
Stayton, Chester A., Indianapolis.
Steffen, J. T., Wabash.
Teeter, E. J., Indianapolis.
Terry, Charles C., South Bend.
Troutwine, William R., Crown Point.
Van Buskirk, E. M., Fort Wayne.
Viney, Charles L., Logansport.
Wagoner, George W., Delphi.
Weiss, H. G., Evansville.
Whallon, A. J., Richmond.
Wiedemann, Frank E., Terre Haute.
Wise, C. L., Camden.
Wiseman, V. Earle, Greencastle.

A. M. A. CONVENTION NOTES

Seventy-eight persons took advantage of the sight-seeing tour to San Francisco and other cities. The party, traveling in four chartered Pullman cars, covered 6,411 railroad miles. It was the first time the association had offered a conducted tour to the A.M.A. session since the meeting was held in Portland, Oregon, some years ago. Everybody who took the trip reported a good time.

One of the busiest men at the session was Dr. R. L. Sensenich, of South Bend, chairman of the Board of Trustees of the A.M.A. Possessed with a tremendous capacity for organization matters, his opinions on the many important issues were constantly sought and respected.

Two of Indiana's four delegates received appointments to Reference Committees. Dr. Don F. Cameron, of Fort Wayne, was named to the Committee on Hygiene and Public Health; and Dr. H. G. Hamer, of Indianapolis, was appointed to the Committee on Industrial Health.

Dr. F. S. Crockett, of Lafayette, another Indiana delegate, made a comprehensive report to the House of Delegates, as chairman of the A.M.A. Committee on Rural Medical Services. "Davy" is looked upon as an authority in this field.

Indiana Medicine was favorably represented at the meeting. Approximately ninety physicians were registered, and a number were on section programs. An interested spectator at all House of Delegate's sessions was Dr. A. M. Mitchell, of Terre Haute, who flew to San Francisco.

Bustling about in his usual busy manner—stopping here and there to say, "Hello," and convey a cheery greeting—was Indiana's popular Tommy Hendricks. Now secretary of the Council on Medical Service, with offices in Chicago, Tommy is devoting most of his time to promoting and co-ordinating the prepayment medical care insurance programs of the various state associations. He is traveling extensively.

Although unable to attend the meeting of the American College of Radiology at San Francisco, on June twenty-ninth, Dr. Raymond C. Beeler, of Indianapolis, was elected to a four-year term as a member of the Board of Chancellors.

Mrs. Samuel J. Petronella, of East Chicago, president of the Woman's Auxiliary; and Mrs. Frank M. Gastineau, of Indianapolis, immediate past president; ably represented the Hoosier state at auxiliary sessions. Mrs. Gastineau gave a report on activities of the Indiana auxiliary for the past year.

The registration at the end of the fourth day was 7,655, against a registration of 5,970 for the same period when the A.M.A. was in "Frisco" in 1938.

Future A.M.A. session plans are as follows: Atlantic City, New Jersey, June 9, 1947; St. Louis, Missouri, May 7, 1948, and New York City, 1949 (tentative).

A. M. A. President-Elect Will Be Banquet Speaker at Annual Meeting

Dr. Olin West, of Chicago, president-elect of the American Medical Association, has been invited to speak at the annual banquet of the Indiana State Medical Association, at the Murat Temple, Indianapolis, Wednesday night, October 30, 1946. He has indicated his acceptance.

For twenty-four years Doctor West was secretary and general manager of the A.M.A., and during this period he has attended numerous medical meetings in Indiana. He has many friends in this state.

In inviting Doctor West to talk at the dinner, the Association is returning to its usual custom of asking the A.M.A. president-elect to be the dinner speaker.

POST-GRADUATE INSTRUCTIONAL COURSES

The Post-graduate Instructional Courses were first offered by the General Arrangements Committee as a special feature of the annual convention of the Indiana State Medical Association in 1943.

The Post-graduate Instructional Courses have proved to be such a popular feature that the Council of the Indiana State Medical Association has requested a continuation of these courses annually.

Again at the convention in Indianapolis, October 29, 30, and 31, 1946, you will have an opportunity to select from one to five class periods from a curriculum of twenty-five courses. Each of these will consist of a single hour devoted to the presentation of a basic problem frequently encountered in general practice.

The object of each course will be to present easily-recognized and frequently-encountered physical signs, symptoms, and disabilities, illustrating them whenever possible.

Each class is to be limited to a number of students sufficiently small to permit a type of instruction with question and answer period from which it is easiest to learn.

The courses will be given on Tuesday, October twenty-ninth, in rooms located in the Murat Temple. The curriculum will be presented to the members of the Indiana State Medical Association beforehand so that advance orders for the desired courses may be submitted to the committee.

Attendance will be limited by ticket, which may be secured at the registration desk on arrival at the convention headquarters, but to insure your admission to the courses you most desire, submit your order for tickets when advance reservations are solicited.

Begin now to plan your arrival in Indianapolis sufficiently early on Tuesday morning, October 29, 1946, to permit your registration and your attendance at these courses.

AMERICAN ACADEMY OF PEDIATRICS

Indiana Study of Child Health Services

The American Academy of Pediatrics has undertaken a nation-wide Study of Child Health Services. During the summer plans are being prepared for Indiana's participation, and the greater part of the work in Indiana should be completed during the remaining months of the year.

In each of the forty-eight states, the District of Columbia, and the Territory of Hawaii, physicians are now organizing study programs under the direction of the Academy state chairman in each state. The Indiana program will be directed by Dr. Ernest R. Carlo, of Fort Wayne, with Dr. Walter Stoeffler, of Indianapolis, serving as executive secretary. The study will gather information from all physicians and dentists; from all hospitals and other institutions providing care for children; and from public and private health organizations concerning well-child conferences, school health programs, public health nursing service, and all other child health activities.

Through personal visits and specially-prepared one- and two-page schedules all medical, dental, public health, hospital, and nursing personnel in the state will be asked to contribute to the study in an effort to obtain an accurate picture of the distribution and extent of the present child health facilities in the state.

Many organizations are now busily engaged in quoting statistics and making recommendations pertaining to the extension of medical care. The Academy has given serious thought to getting the basic data needed in sound planning for the health and medical care of our children. There is a definite and vital need for this study as the first step toward such planning. Indiana pediatricians have taken the initiative here in assuming the responsibility for the conduct of the study, but it is up to each one of us concerned with child health to do our share in making this a thorough, fact-finding study, which will show us where we now stand and what our needs are for the future.

Ernest R. Carlo, *State Chairman*,
American Academy of Pediatrics
Indiana Study of Child Health Services.

Military News

Lieutenant William G. Clevinger, of Indianapolis, is reported to have left the United States, and is at present in Japan.

Captain J. C. Glackman, Jr., of Rockport, has re-opened his office in the Lieb Building there. Doctor Glackman served for three years with the Medical Corps in the Mediterranean Theatre.

Major Lawson J. Clark, of Indianapolis, at present at Gardiner General Hospital, in Chicago, expects to be released from service about the middle of August.

Recently separated from the United States Army Medical Corps with the rank of major, after many months' service in the United States and in the Pacific theatre of operations, Dr. James R. Woods, Jr., has reopened his office in Greenfield.

Information has been received that Commander Waite R. Griswold, formerly of Indianapolis, is now serving as the senior medical officer at the United States Naval Prison, in Portsmouth, New Hampshire.

Separated from the Army with the rank of Captain, Dr. Victor F. Albright, of Indianapolis, is now a resident at the Indiana University Medical Center. Doctor Albright was in service for three years, two of which were spent with the 323rd Bomb Group in the ETO.

Lieutenant Eugene Rifner, of Indianapolis, has received orders to proceed to Fort Knox, Kentucky, where he will be given further assignment of duty with the Army Medical Corps. Doctor Rifner recently completed his internship in St. Vincent's Hospital, in Indianapolis.

A former flight surgeon in the Army, and a native of Erie, Pennsylvania, Dr. Frank C. Bower has assumed his duties as a member of the medical staff at the Logansport State Hospital, in Logansport.

Captain J. B. Wohlfeld has established an office at Bedford following his recent release from the Army. Doctor Wohlfeld is a graduate of the Indiana University School of Medicine, and he served his internship at the Indiana University Medical Center. Shortly after completing his training, in 1943, he was inducted into the Army, where he served as a battalion surgeon. He also had a residency in surgery in the Army.

Lieutenant Lewis E. Morrison, II, of Indianapolis, who has been located at Camp Atterbury, has been transferred to Fort Sam Houston, in San Antonio, Texas.

Dr. Joseph Bernstein, formerly of Indianapolis, and only recently released from the Army, after more than two years in Europe, has moved to New York, where he is now practicing general medicine.

Captain Joseph L. West has returned to his former office, at 6318 West Washington Street, Indianapolis, following his release from service, early in May. Doctor West spent fourteen months in England, and was headed for the Pacific when the war ended.

Lieutenant Robert J. Lehman, of Berne, has recently been reactivated into Army duty, and expects to be stationed at Fort Hayes, in Columbus, Ohio, for two months, following which he will go to Fort Sam Houston, San Antonio, Texas. Doctor Lehman is a graduate of the Indiana University School of Medicine.

Lieutenant-colonel E. L. Libbert, of Lawrenceburg, was released from service on May second. He had been in the Army for four years, the last year of which was spent in India. Doctor Libbert has moved to Indianapolis, where he will be connected with the Veterans Bureau, as a roentgenologist.

Lieutenant Charles Pierre DeLawter, who graduated from the Indiana University School of Medicine in 1942, was married in New York on June third to Miss Rose Bontsik. Lieutenant DeLawter is in the Regular Navy, and is now located at the United States Naval Hospital at Long Beach, California.

Major William L. Wissman has established an office in Columbus. A graduate of the Indiana University School of Medicine, in 1941, Doctor Wissman entered the Army Medical Corps in 1942, and served with the 96th Infantry Division on Okinawa and in the Philippines. He has been taking postgraduate work at the Indianapolis City Hospital and the Indiana University Medical Center since his release from active service last December.

After serving in the Army for four years at the Halloran General Hospital, in New York, and Walter Reed General Hospital, in Washington, D. C., Dr. George T. Paulissen, of Indianapolis, has returned to Indianapolis, and is serving as anesthetist at St. Vincent's Hospital. Doctor Paulissen served with the rank of captain.

Captain Hunter F. Kennedy, of Indianapolis, has been separated from service recently, and has opened an office in the Fountain Square Theater Building, in Indianapolis. Doctor Kennedy spent twenty months in the Army, and served for thirteen months in Alaska, with the 206th Station Hospital.

Discharged with the rank of lieutenant-commander, after three and one-half years' service with the Navy Medical Corps in the Atlantic and Mediterranean area, Dr. John I. Rinne, Jr., formerly of Anderson, is now practicing obstetrics and gynecology at 314 Hume Mansur Building, Indianapolis.

Lieutenant Hilbert Haines DeLawter, of Indianapolis, who had been stationed at the Veterans Administration Hospital, at Danville, Illinois, has been discharged from the armed forces and is attending the Menninger Foundation School of Psychiatry, at Topeka, Kansas.

Having received his discharge from the Navy in June, Lieutenant John J. Cacia has returned to Evansville to resume his practice there. Doctor Cacia completed tours of duty with hospital units of the Fifth Marine Division in the Hawaiian Islands and Japan, and with the Sixth Marine Division in China.

A veteran of World War II, who served as a flight surgeon with the Army Air Forces in the European Theatre of Operations, Captain Richard C. Miller, formerly of Indianapolis, has opened an office for the practice of medicine in Shelbyville. Doctor Miller practiced medicine for four years in Indianapolis prior to his entrance into service four years ago.

Recently placed on inactive status at the William Beaumont General Hospital, in El Paso, Texas, Major Richard C. Stauffer, of Fort Wayne, has resumed his practice there. While in service Doctor Stauffer served as chief of an orthopedic section, and received his release from active duty at the William Beaumont General Hospital, at El Paso. A graduate of the 1938 class of the Indiana University School of Medicine, he served a two-year internship at the Indianapolis City Hospital, and a three-year residency in orthopedic surgery at the University and Crippled Children's Hospital, in Oklahoma City, before entering the Army.

Dr. Raymond E. Robertson, son of Dr. and Mrs. Ray B. Robertson, of Indianapolis, was married in Chicago on May twenty-fifth to Miss Mary Helen Bassett, of Desplaines, Illinois. Doctor Robertson, who completed his internship at St. Luke's Hospital, in Chicago, reported on July first for active duty in the Medical Corps, with the rank of lieutenant.

Captain Elsworth K. Stucky is another Indianapolis physician recently released from the Army. Doctor Stucky spent forty-four months in the service, thirty months of which were spent in North Africa and Italy, with the 34th and 85th Infantry Divisions, and the 262nd Station Hospital.

Discharged with the rank of Captain, Dr. James W. Young, of Indianapolis, has resumed his practice, but has not yet located an office. Doctor Young spent two and one-half years in the Army, most of which time was spent in Europe, where he was commanding officer of a Collecting Company of the 87th Division in the Third Army.

Commander Harry E. Kitterman, of Indianapolis, has returned from four years of naval service, to resume his practice of orthopedic surgery in the Hume Mansur Building. Doctor Kitterman was stationed for two years at Quantico, Virginia, spent one year at Pearl Harbor, and completed a tour of duty in the Philippines. This last assignment was cut short when Doctor Kitterman suffered a broken leg in a landing-craft accident in Manila.

A veteran of three and one-half years with the Army Medical Corps, Dr. John P. Scherschel has established an office in Bedford. He is a graduate of the Indiana University School of Medicine, and served his internship at the Indianapolis City Hospital. Following this he served in the Army Medical Corps in the Pacific Theatre of Operations. Doctor Scherschel was separated from service last November, and has been taking additional training at the Indianapolis City Hospital since that time.

Lieutenant G. R. Bloom has leased the office and equipment of Dr. Carl Vetter, in the Monger Building, in Elkhart, and has begun the practice of medicine there following his recent discharge from the Navy. Doctor Bloom, a graduate of the Indiana University School of Medicine, served in the Navy for four years, during which time he was stationed at the Marine Hospital and the Naval Hospital at New Orleans; at Washington, D.C.; and in Bermuda. He served in the Naval Submarine Base, at New London, Connecticut, and was at Great Lakes, Illinois, for six months prior to his discharge. Doctor Vetter now resides in Florida.

Captain Fred K. Allen, of Salem, recently received the Bronze Star Medal for meritorious achievement in connection with military operations in Luzon, Philippine Islands, during the period of January 30 to June 20, 1945. The citation accompanying the award stated that "Captain Allen was dispensary officer and registrar of an amphibian medical company which hospitalized, evacuated, and treated an unprecedented number of patients, far in excess of its designated capacity. Doctor Allen served in the Army from July, 1942, until December, 1945, including thirty-one months in the South Pacific. He recently purchased a residence in Salem, where he has resumed his practice of medicine.

Captain Paul Des Jean, of Indianapolis, who entered the Army upon completion of his internship at the Indiana University School of Medicine, on December 31, 1943, was discharged on June 30, 1946. He first spent six weeks at Carlysle Barracks, then six weeks in dermatology at the Walter Reed General Hospital, in Washington, D.C., and was assigned to the 95th Infantry Division as battalion surgeon of the 358th Field Artillery Battalion. He was in Europe for a year, participating in the Northern France, Central Europe, and Rhineland Campaigns, and was awarded the Bronze Star Medal for meritorious service in the Metz campaign. In June, 1945, Captain Des Jean was returned to the United States, and was stationed at Camp Shelby, Mississippi, as personnel center surgeon. After four months he was made executive officer of the station hospital, and remained in this capacity until separated from service. Doctor Des Jean is entering the general practice of medicine at 316 Pennway Building, in Indianapolis.

A veteran of sixty-five months of active duty, Colonel David H. Sluss, of Indianapolis, has been released from the Army, and has resumed the practice of surgery in the Chamber of Commerce Building, in Indianapolis. Doctor Sluss entered the service with the 38th Division when the National Guard was mobilized, in January, 1941, and served with the 113th Medical Regiment, at Camp Shelby, until the Division was triangularized. As commanding officer of the 30th Station Hospital, he then went to Persia, in 1942, where he established the first American Hospital in Teheran. After eighteen months, Doctor Sluss then returned to the United States, on rotation, and went to Camp Barkley, where he activated the 180th General Hospital. In October, 1944, he went to Rouen, France, with the 179th General Hospital. In August, 1945, this hospital was prepared for duty in the Pacific, but at the conclusion of the war with Japan the unit was transferred to Paris, and occupied the Hospital Boujon, which had been used by Goering for the Luftwaffe during the German occupation of France.

Dr. Frederic L. Schoen, formerly of Saint Louis, Missouri, has become associated in the practice of medicine and surgery with Dr. Nathan L. Salon, in Fort Wayne. Doctor Schoen is a veteran of World War II, having entered the Navy in September, 1943. He served for two months at the San Diego Naval Hospital, and for twenty-six months aboard the *U. S. Rutilicus*, participating in the invasions of Tarawa, Kwajelein, Saipan, Leyte, Okinnawa, and Nagasaki, Japan. He is a graduate of Washington University School of Medicine, in Saint Louis.

Apparently the past five years in the Naval Air Corps have proved satisfactory to Captain Harold E. List, of Marion, for he is planning to remain in the Navy. Upon entering service in June, 1941, he was stationed as flight surgeon at the Naval Air Station, at Grosse Ile, Michigan, until May, 1942, when he was transferred to the Naval Air Facility, at Columbus, Ohio. He served there for two years as senior medical officer and flight surgeon. A tour of sea duty came next, and Captain List went to the *USS Belleau Wood*, a carrier, as senior medical officer and flight surgeon. In February, 1945, Captain List entered the Marine Corps Air Station, at Ewa, Oahu, in Hawaii, where he served in the same capacity until May, 1946. At present he is on leave. Captain List holds a Presidential Unit Citation for the *Belleau Wood*, which suffered extensive damage and the loss of quite a few men when the ship was hit by a Kami-kaze just off the Philippines.

Major C. Powell Van Meter, of Indianapolis, is planning to enter general practice at 3419 East Tenth Street in Indianapolis, in the near future. He was separated on July sixth, after thirty-one months of service. In November, 1944, Major Van Meter went overseas with the 87th Division as company commander of a collecting company, medical battalion. It is a coincidence that he was accompanied by James Young, of Indianapolis, and Tony Nolke, of Mishawaka, all three being 1942 graduates of the Indiana University School of Medicine, and all three assigned to the same organization in the same division, remaining together throughout their Army career. He entered combat at Metz, went on through the Battle of the Bulge and Central Germany, and was on the border of Czechoslovakia when the war ended. He was returned to the United States in July, 1945, destined for the Pacific, but the end of the war prevented that, and the 87th Division was demobilized. He then became Chief Medical Examiner with the Armed Forces Induction Station, at Fort McClellan, Alabama, where he remained until he was separated from service. Doctor Van Meter has the Bronze Star Medal, the Combat Medics Badge, and wears three battle stars on his ETO ribbon.

MAJOR JOHN D. WINEBRENNER NAMED CIVILIAN MEDICAL DIRECTOR OF BREMEN DISTRICT IN GERMANY

After two years of distinguished service in the European Theatre, Dr. John D. Winebrenner, of Muncie, has embarked upon a new mission, that of Civilian Medical Director with the occupation forces of the Bremen District in Germany, under the War Department's Civil Affairs Division. He served with the occupation forces during the war, and helped organize the European Civil Affairs Division.

Major Winebrenner is a graduate of the Indiana University School of Medicine, and was District Director of the Indiana State Board of Health until he entered the service on July 29, 1942, having been a reserve officer since 1939. He first served as Post Venereal Disease Control Officer at Camp Atterbury, then was ordered to the Provost Marshal General School, at Fort Custer, Michigan, a school of general training for occupation services, and later was sent to the Civil Affairs Training School at the University of Michigan, at Ann Arbor. He was then sent to England to help organize the medical branch of the European Civil Affairs Division, called the "ECAD."

On D-Day plus thirteen he entered Normandy with the Headquarters of the First United States Army, remaining there throughout the campaigns of Normandy and Northern France, until Aachen fell. On October 24, 1944, he left the Headquarters of the First Army and joined the Berlin team, whose duty it was to form a group to go in and take over the City of Berlin, this combined group, half British and half American, being called the Military Government of the Greater Berlin Area —the "MGGBA." This group trained and planned for the joint Berlin occupation at Barbizon, France; however, that occupation did not materialize due to changes brought about in the war.

On May 1, 1945, Major Winebrenner was assigned as Chief Public Health Officer for the Enclave of Frankfurt an Main, and on July 25, 1945, he was transferred to Chief Public Health Officer of the Province of Baden, where he remained until his return to the United States on December 21, 1945.

Major Winebrenner explained that the Germany he entered was quite different from the Germany he left behind, for in those few months what had been a devastated desert, except for people living among the rubble in primitive mode and in chaotic and disorganized conditions, had by this time improved to the extent that streets were open and telephone systems established within the larger cities, and it had again taken on the semblance of a civilized country.

On query as to the most interesting part of his work, Major Winebrenner pointed out the setting up of Frankfurt so that the Supreme Headquarters of the American Expeditionary Forces—SHAEF—could move in. This involved the transporting of all displaced persons, and the biggest problem for the first few days was the handling of the mobs of so-called "slave laborers"—Russians, Poles, Czechs, and French. They had been released from German restraint, and the Americans had to assume control of them and arrange for housing, feeding, and rehabilitation, including medical care, checking of epidemics, et cetera. Every single element of the public health had to be reconstructed. Some medical (American) officer had to assume the responsibility of directing the nominations of various chiefs of hospital services, and had to supervise a German medical board assigned to take over and carry out the reorganization of the hospital system. The Public Health Department of the City of Frankfurt had less than 10 per cent of its former personnel available, and it faced a public health project that would tax an organization many times its size. The Military Government medical staff at first had to issue orders and actually take direct control of sanitation, medical care, evacuation, supply of drugs, and the inspection of food supplies. With the inspection of food supplies there was one primary purpose: it was absolutely necessary to prevent the outbreak of epidemics among the German population in order to prevent disease among the American forces. Initially the concern was typhus fever; and secondarily, typhoid and the acute communicable diseases. Water conditions had to be checked and secured against a spread of water-borne disease, and German civilians had to be dusted with DDT.

Finally, after several months the emphasis was shifted to VD Control. Personnel for carrying out this work was at first non-existent. First, they had to find German people with technical ability; and secondly, find persons with character and the ability to command and supervise other people, persons willing and able to carry out the job. They did not have time to experiment; but they did not use Nazis for this work.

In organizing the provincial Baden government—the medical and public health services in the Province of Baden—they formed their own government on a pattern of the ancient Province of Baden, and later it was combined into the Wurttemburg-Baden Government.

Another achievement was the opening of the Heidelberg School of Medicine, under the immediate supervision of Major Winebrenner. Fortunately, this had been an open city and thus had not been badly damaged, but a satisfactory medical staff had to be obtained to run the school and get it in operation. First a two-month refresher course was given German medical officers who had returned, and later they opened the regular school of medicine, for Germany needed more doctors. It had suffered a considerable loss of doctors, and

many had been held to care for prisoners of war in the American and allied occupation zones. For instance, a staff of German medical officers must be maintained to care for the prisoners of war now used in rehabilitating Holland, Belgium, Russia, and France. Accordingly, Germany needed at least one medical school, and they got it started.

Major Winebrenner has five stars awarded for the Normandy, Northern France, Ardennes, Rhineland, and Central Europe campaigns. He was separated April 9, 1946.

Doctor Winebrenner is taking his wife and six-year-old daughter with him to Germany, where they will live in the American colony in Bremen, and they expect to be gone a year or two. *Auf Wiedersehen!*

Deaths

Giles E. Mowrer, M.D., of Jeffersonville, died on May twenty-eighth at the age of seventy-two. He graduated from the University of Louisville School of Medicine in 1912, and had practiced in Jeffersonville for twenty-eight years.

Floyd L. Grandstaff, M.D., of Decatur, died on May eleventh, at the age of forty. He graduated from the Indiana University School of Medicine, in 1928, and had served as a major in the Army Medical Corps during World War II, being released from active duty in March of this year. He was a member of the Adams County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Sidney J. Hatfield, M.D., of Indianapolis, was killed in an automobile accident at Willits, California, on July seventeenth. He was sixty-six years of age. Doctor Hatfield had retired two weeks earlier, and was on a vacation trip through the West. He was a graduate of the Hospital College of Medicine, in Louisville, Kentucky, in 1902, and had practiced medicine in Indianapolis for forty-four years, specializing in obstetrics. Doctor Hatfield was a member of the Indianapolis (Marion County) Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

George S. Porter, M.D., of Williamsport, died on June twenty-ninth at the age of seventy-six. He was a graduate of the Illinois Medical College, in Chicago, in 1901, and had practiced in Williamsport until he died. Doctor Porter was a member of the Fountain-Warren County Medical Society, the Indiana State Medical Association, and the American Medical Association.

L. R. Crabtree, M.D., of Columbus, died June twenty-eighth at the age of fifty-eight. Doctor Crabtree was a graduate of the University of Tennessee College of Medicine, in Memphis, in 1910, and was especially interested in obstetrics. He was secretary of the Columbus City Board of Health, and was a member of the Bartholomew County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Edwin L. Sigmon, M.D., of Floyds Knobs, died on June twentieth, after a long illness. He was eighty years of age. Doctor Sigmon was a graduate of the Kentucky School of Medicine, in Louisville, in 1886, and had practiced medicine for almost sixty years in Floyd County. He was an honorary member of the Floyd County Medical Society, the Indiana State Medical Association, and the American Medical Association.

A. M. A. OFFICERS ELECTED

Dr. Harrison H. Shoulders, of Nashville, Tennessee, advanced to the presidency of the American Medical Association at the recent A.M.A. session, in San Francisco. He will serve until next June, when, at Atlantic City, New Jersey, he will be succeeded by Dr. Olin West, named president-elect.

Prior to his retirement early in 1946, Doctor West had served as Secretary and General Manager since 1922. Thus his previous devoted service to American Medicine was fittingly recognized.

Dr. Edward L. Bortz, of Philadelphia, Pennsylvania, was elected vice-president, and Drs. George F. Lull, of Chicago, and Josiah J. Moore, also of Chicago, were re-elected secretary and treasurer, respectively. Dr. R. W. Fouts, of Omaha, Nebraska, was re-elected speaker of the House of Delegates, defeating Dr. Lowell S. Goin, of Los Angeles, California, by a vote of ninety to seventy-seven.

News Notes

Dr. Caroline M. Goodwin, of Indianapolis, has been elected vice-president of the Alumni Association of the College of Arts and Sciences of Indiana University.

Announcement has been made of the appointment of Dr. Foss Schenck, of Logansport, as assistant superintendent of the Logansport State Hospital.

Physicians are being offered positions in the Philippines by the Veterans Administration, Dr. E. H. Hare, chief medical officer of the Veterans Hospital in Indianapolis, has announced. Applicants should contact the personnel office of the Veterans Hospital, on Cold Springs Road, Indianapolis.

Dr. C. C. Bosselmann, formerly of Fort Wayne, has opened an office in Argos for the general practice of medicine. He is associated with Dr. P. R. Irey and Dr. H. D. Tripp, who operate a clinic in Plymouth. Doctor Bosselmann will spend most of his time in Argos, and Doctors Irey and Tripp will serve as consultants.

Dr. Margaret A. Bassett became associated with her father, Dr. Clancy Bassett, in the general practice of medicine at Thorntown, on July fifteenth. For the past three years she has served as physician at Indiana University, at Bloomington. She also served as physician for the 1551st Service Unit of the United States Army, which was stationed in Bloomington.

A personally-signed Certificate of Merit from President Truman has been received by Dr. Charles R. Bird, of Indianapolis, commending him for his activities as chairman of the Procurement and Assignment Service for Indiana. A letter of appreciation from Dr. Frank H. Lahey, chairman of the Procurement Board, in Washington, was also included with the Certificate.

Dr. Joseph W. Ricketts, of Indianapolis, was installed as national president of the American Proctologic Society, at the Society's annual convention, in San Francisco, California, in June. Doctor Ricketts, in collaboration with Dr. John A. Campbell, of Indianapolis, presented a paper on "Use of Radon Ointment in the Treatment of Post-irradiation Lesions of the Rectum." Doctor Ricketts also presented a comprehensive report on public relations.

Dr. James G. Shanklin, of Hammond, has gone to Fort Stellacoom, Washington, where he will take a three-year residency in psychiatry at the Western State Hospital.

Dr. Jonathan Yoder, of Goshen, closed his office there recently, and plans to return to India as a missionary. Doctor Yoder has been on an eighteen-month leave of absence from the Mennonite mission field.

Dr. F. H. Austin, of Bloomington, was appointed Monroe County jail physician by the county commissioners, on July second. Doctor Austin succeeds Dr. O. Floyd Rogers, of Bloomington, who resigned after serving for the first half of the year.

On June 16, 1946, the members of the American Society for the Hard of Hearing voted to change the name of their organization to the American Hearing Society. This change was made in order to place emphasis on "hearing." The address is 1537 Thirty-fifth Street, N.W., Washington 7, D.C.

ORIENTATION COURSE IN CLINICAL ALLERGY

An orientation course in clinical allergy, under the sponsorship of the American Academy of Allergy, will be held October 7, 8, 9, 10, 11, 1946, inclusive, at the Marquette University School of Medicine, in Milwaukee, Wisconsin.

Announcement was made recently of the appointment of Dr. A. C. Bartholomew, of Fort Wayne, as authorized ophthalmic examiner for the Civil Aeronautics Administration. The appointment enables him to certify commercial pilots under the new regulations adopted on May first, on recommendation of the National Research Council's Committee on Medical problems in civil aviation.

At a recent meeting of the Indiana State Medical, Dental, and Pharmaceutical Association, in Gary, Dr. A. C. Payne, of East Chicago, was named president-elect, and Dr. D. A. Bethea, of Hammond, was elected secretary. Terre Haute was chosen for the annual convention next year, when the association will resume joint meetings with the Indiana State Tuberculosis Association. The combined meetings were discontinued during the war. Dr. M. H. Lovell, of Gary, was appointed to the Council. Dr. A. C. Payne was one of the speakers on the program.

Dr. George Willison and Dr. P. J. V. Corcoran have opened an office in Evansville for the practice of medicine. They will limit their practice to diagnosis and internal medicine. Doctor Willison has been associated with Dr. Herman M. Baker, of Evansville, for almost eight years, and Dr. Corcoran has practiced with Dr. William L. Harris and Dr. C. W. Yeck, of Evansville.

AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians has announced that its Twenty-eighth Annual Session will be held in Chicago on April 28 inclusive of May 2, 1947. Dr. David P. Barr, of New York, president of the College, will be in charge of the program of General Sessions and Lectures. Dr. LeRoy H. Sloan, of Chicago, has been appointed General Chairman, and will be in charge of the program of Hospital Clinics and Panels, as well as local arrangements, entertainment, et cetera. Mr. Edward R. Loveland, Executive Secretary of the College, 4200 Pine Street, Philadelphia 4, will have charge of the general management of the session and the technical exhibits.

A half a century of medical service was celebrated on June nineteenth by Dr. L. H. Eshleman, of Marion, when he entertained his friends and associates at a dinner party. Guest speakers were Dr. Jesse Ferrell, of Fortville, and Mr. Ray E. Smith, of Indianapolis, president and executive secretary, respectively, of the Indiana State Medical Association. Members of the Grant County Medical Society and their wives were guests. Doctor Eshleman graduated from the Kentucky School of Medicine, in Louisville, Kentucky, in June, 1896, and entered practice at Marion. He has served as president of the Grant County Medical Society, president and secretary of the Marion City Board of Health, member of the Pension Board, and City Health Officer.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

The American Congress of Physical Medicine will hold its twenty-fourth annual scientific and clinical session on September 4, 5, 6 and 7, at the Hotel Pennsylvania, in New York. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 4, 5, and 6. These courses will be open to physicians and to therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

Dr. Carl C. Kuehn, of Indianapolis, has been appointed director of the Division of Tuberculosis Control of the Indiana State Board of Health, succeeding Dr. Holland Thompson, who resigned recently. Doctor Kuehn is a native of Indianapolis, a graduate of Indiana University School of Medcine, and served his internship at the Methodist Hospital, in Indianapolis. He has been a medical officer in the United States Public Health Service, in Louisiana, for the past four years.

The War Department announced, on June twenty-first, the appointment of Dr. John H. Greist, of Indianapolis, as one of eighteen civilian neuropsychiatrists to serve as consultants to the United States Surgeon General. The former Medical Corps officers were appointed to evaluate, promote, and improve the quality of medical care given to the American soldier, according to the announcement. Doctor Greist, who served in a similar capacity during part of his five years' service in World War II, was placed on the reserve list as a colonel on April first. The appointment is of a consultant nature, and Doctor Greist plans to continue his private practice.

ONE-THOUSAND-DOLLAR AWARD OFFERED IN THESIS CONTEST

Announcement has been made of the Schering Award for 1946, a competition open to undergraduate medical students. "The Role of Hormones in Sterility," is the subject of this year's contest, the purpose of which is to encourage medical students to delve into various fields of endocrinology. The award is sponsored by the Schering Corporation, of Bloomfield, New Jersey, manufacturers of endocrine and pharmaceutical products. An award of five hundred dollars is offered for the best thesis submitted; for the second and third best papers, awards of three hundred dollars, and two hundred dollars, respectively, will be paid.

Fifty years as a practitioner of medicine in Portland were observed in June by Dr. W. D. Schwartz, of Portland. Graduating from the Medical College of Indiana, in Indianapolis, in 1896, Doctor Schwartz served his internship at the Indianapolis City Hospital, and then returned to Portland to establish his practice. The first x-ray equipment used in Portland was installed in Doctor Schwartz's office. In 1898 he gave antitoxin to a child critically ill with diphtheria. At that time antitoxin was still so new it had to be imported from abroad. He has served on the school board, as an officer in several industries, and during both World Wars has examined inductees. He has four citations, signed by the President, for World War II. Doctor Schwartz intends to continue with his practice, hoping to fulfill a prediction he made a quarter of a century ago, to the effect that one day he would make his calls in an airplane.

WAYNE UNIVERSITY OFFERS COURSE IN OCCUPATIONAL HEALTH AND MEDICINE

The Wayne University School of Occupational Health has offered a fifteen-week orientation course in Occupational Health and Medicine, beginning September 9, 1946. The courses are designed for physicians who are engaged in industrial medical practice, and include both classroom and in-plant service. Enrollment is limited to twenty-five students. For further information address the Dean, School of Occupational Health, 1547 Penobscot Building, Detroit 26, Michigan.

Dr. H. B. Gable, who has practiced medicine in Monticello since 1909, has left for an extended vacation in the west. Having practiced continuously for over thirty years, he feels he has earned a rest, and has purchased a trailer and plans to travel for the next year or longer. His practice is being taken over during his absence by Dr. Nolan A. Hibner. Upon his return, Doctor Gable plans to remodel his office, to provide office space for himself and Doctor Hibner.

Dr. Harry Knott, of Plymouth, a pioneer in x-ray work in northern Indiana, has resigned as head of the x-ray department of Parkview Hospital, in Plymouth, due to ill health. Doctor Knott purchased the first x-ray equipment in Marshall County, and made the equipment available for general use of all of the physicians in that area. When he became radiologist in the Parkview Hospital, Doctor Knott kept adding to and replacing equipment with new and better equipment.

A sectional meeting of the National Foundation for Infantile Paralysis was held on June tenth, at the Fowler Hotel, in Lafayette. Dr. Carl D. Martz, of Indianapolis, was the principal speaker of the evening, his address being entitled "Helping Hands." Dr. E. T. Stahl, of Lafayette, president of the Tippecanoe County Medical Society, spoke on "Available Facilities for Treatment of the Patient"; and Dr. W. C. Anderson, of Terre Haute, director of the northwestern office branch of the Indiana State Board of Health, discussed "Services to the Community." Mr. John B. Middleton, regional director of the National Foundation for Infantile Paralysis, spoke on "Importance of Coordination of Services." Approximately fifty persons attended the meeting.

Recently discharged from the United States Army, Dr. Robert A. Staff, of Rockville, has been re-appointed superintendent of the Indiana State Sanatorium, at Rockville. Dr. Hubert B. Pirkle, of Rockville, who has served in that capacity since July, 1942, when Doctor Staff was given a leave of absence to enter the armed forces, will now become first assistant medical director at the Sanatorium, the position he held when Doctor Staff entered the service.

CENTRAL STATE HOSPITAL REPRESENTED AT SAN FRANCISCO MEETINGS OF AMERICAN MEDICAL ASSOCIATION AND AMERICAN NEUROLOGICAL ASSOCIATION

The Central State Hospital, of Indianapolis, was represented by a scientific exhibit, entitled "Pathogenesis and Treatment of Syphilitic Primary Optic Atrophy," at the meeting of the American Medical Association which was held in San Francisco, July 1-5, 1946. Co-sponsors of the exhibit were the American Society for the Prevention of Blindness, and the American Social Hygiene Association.

New treatment schedules which will arrest advancing syphilitic blindness due to optic atrophy was demonstrated by Dr. Max A. Bahr and Dr. Walter L. Bruetsch.

At the meeting of the American Neurological Association, in San Francisco, June 26-28, the Central State Hospital physicians read a paper on "The Surgical Treatment of Syphilitic Primary Optic Atrophy."

In the Section on Nervous and Mental Diseases of the American Medical Association a paper on "Rheumatic Brain Disease—Late Sequel of Rheumatic Fever" was presented by the research staff of the institution.

INDIANA PHYSICIANS PARTICIPATED IN A.M.A. SESSIONS

The Indiana State Medical Association was well represented at the recent meeting of the American Medical Association, several members taking part in the program.

Dr. Carl H. McCaskey, of Indianapolis, addressed the Section on Laryngology, Otology, and Rhinology, on the subject, "Treatment of Neck Infections." He also presented lantern slides.

Dr. Walter L. Bruetsch, of Indianapolis, read a paper on "Rheumatic Brain Disease: Late Sequel of Rheumatic Fever," and also gave a lantern demonstration. He, together with Dr. Max Bahr, representing the Central State Hospital, had a scientific exhibit, entitled "Pathogenesis and Treatment of Syphilitic Primary Optic Atrophy." Co-sponsors of the exhibit were the American Society for the Prevention of Blindness and the American Social Hygiene Association.

Dr. George J. Garceau, of Indianapolis, was one of the demonstrators in the presentation of a special exhibit on fractures, and also led a discussion on the subject, "Conservative Treatment of Low Back Pain, Including Suspected Disk Lesions," presented before the Section on Orthopedic Surgery.

Dr. E. J. Teeter, of Indianapolis, appeared before the Section on General Practice of Medicine, discussing "Bile Physiology and Therapy," illustrating his talk with lantern slides.

Dr. Hedwig S. Kuhn, of Hammond, presented a paper and lantern demonstration on "Industrial Ophthalmology as of 1946," before the Section on Ophthalmology. Dr. Robert J. Masters, of Indianapolis, is secretary of the section.

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INDIANA UNIVERSITY NEWS NOTES

Dr. Willis D. Gatch, who served as dean of the Indiana University School of Medicine since 1930, resigned as dean of the school on July first. He joined the staff of the Indiana University School of Medicine in 1912 as professor of surgery.

During Dr. Gatch's connection with the school, it became one of the largest in the country, and in 1944 no other medical school graduated more new M.D.'s. During his sixteen years as dean, no graduate ever failed to pass the Indiana State Board examination for a practicing license.

An eminent surgeon as well as an educator, Dr. Gatch is the author of eighty-four scientific articles and several sections in surgical textbooks. A native of Aurora, Indiana, Dr. Gatch was graduated from Indiana University in 1901, and from there he went to the Johns Hopkins Medical School, where he was granted his degree in 1907. He was an assistant resident surgeon in the Johns Hopkins Hospital from 1907 to 1911.

He went from there to the Washington University Hospital in St. Louis, where he was chief resident surgeon. It was while he was there that Indiana University induced him to come to Indiana as a professor of surgery. Dr. Gatch is a former president of the Western Surgical Association, a Fellow of the American College of Surgeons, and a member of the Central Surgical Association, the Southern Surgical Association, and the American Medical Association, as well as the Western Surgical Association.

It was while Dr. Gatch was a young resident at the Johns Hopkins Hospital that he invented a device that has made his name a "household word" at all hospitals. This is the "Gatch bed," which enabled a patient to be raised to a sitting position.

The young Dr. Gatch was "wrestling" one night with a huge patient weighing well over two hundred pounds, trying to get him into a sitting position, when it occurred to him that there should be some easier way of doing this job. The "Gatch bed" was the result.

At first one raised the upper portion of the bed by hand. It was once being used in the Henry Ford Hospital, in Detroit, when Henry Ford saw it and decided that an improvement should be made. He set an engineer to work on the problem, and a crank-and-screw attachment which makes raising the bed a simple matter of turning a small wheel was added.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

June 3, 1946.

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D., and Ray E. Smith, executive secretary.

The following news releases for the "Hints on Health" column for weekly newspapers were approved:

Week of June 17, 1946—"Swat the Fly!"

Week of June 24, 1946—"Moving Injured Persons."

Week of July 1, 1946—"Arch Supports."

Receipt of a series of thirteen records, entitled "Time Out," from the American Medical Association, for use by WFBM each Monday afternoon in place of the "Ladies, Your Health" program was reported by the secretary. The series will conclude on Monday, August 26, 1946. An invitation for bureau members to meet at radio station WFBM at 4:00 P.M., Monday, June 17, to hear some of the records was accepted.

A recommendation by the Council on Medical Service and Public Relations that the bureau prepare a brochure describing the objectional features of the Wagner-Murray-Dingell Bill and answering the arguments of the proponents of the measure was presented by the secretary. The brochure would be for circulation among Indiana high school pupils who are debating the bill, and for general distribution. The secretary was instructed to write to the Council on Medical Service and Public Relations of the American Medical Association to see what it has available.

BUREAU OF PUBLICITY

June 17, 1946.

Present: H. G. Hamer, M.D., chairman; Ben B. Moore, M.D., and Ray E. Smith, executive secretary.

Two fifteen-minute recordings of the "Time Out" radio series, broadcast each Monday afternoon over WFBM under sponsorship of the bureau, were played.

The following news releases for daily newspapers were approved:

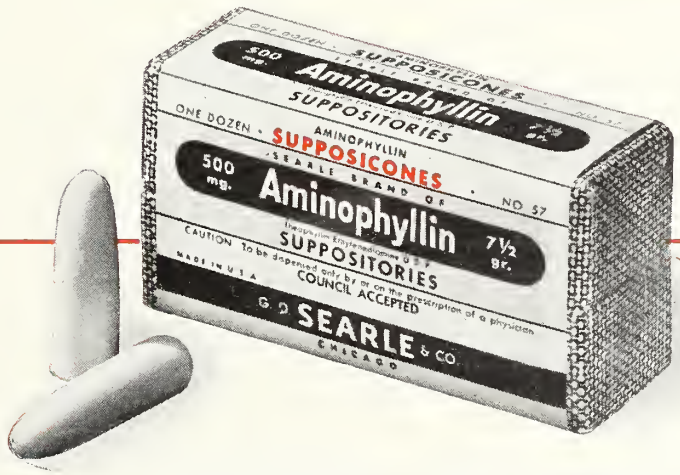
Monday, June 24, 1946—"Beware of Too Much Sun."

Monday, July 8, 1946—"Ivy Poisoning."

The following releases for the "Hints on Health" column for weekly newspapers were approved:

SEARLE RESEARCH

has produced an improved AMINOPHYLLIN SUPPOSITORY



AMINOPHYLLIN SUPPOSICONES

Searle brand of AMINOPHYLLIN SUPPOSITORIES

This new suppository—known as the Searle Aminophyllin Supposicone—has these advantages:

1. It remains stable outside the body at temperatures up to 130° F.
2. It liquefies rapidly inside the rectum at normal body temperature.
3. It is nonirritating to the rectal mucosa; no anesthetic is required.
4. It provides an excellent vehicle for prolonged medication.
5. It contains 500 mg. (7½ gr.) of Searle Aminophyllin, having at least 80% of anhydrous theophyllin.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Supposicone is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Week of July 8, 1946—"Dangers of Tennis."
Week of July 15, 1946—"Ice in Cold Drinks."
Week of July 22, 1946—"The Pesky Chigger."
Week of July 29, 1946—"Patent Medicine."

A letter from the Council on Medical Service and Public Relations of the American Medical Association, explaining that literature was being prepared setting out arguments against compulsory health insurance, was read.

A postal card notice from the Washington office of the A. M. A. Council on Medical Service and Public Relations, stating that hearings had started on the EMIC bill and that the association was privileged to send a statement to the Senate Committee, was referred to the Advisory Committee to the Bureau of Maternal and Child Health of the Indiana State Board of Health.

The secretary reported that the Executive Committee had decided that the association should join with the Indiana State Board of Health in using exhibit space at the Indiana State Fair, and that Dr. Ferrell, association president, was going to appoint a Committee on State Fair.

LOCAL SOCIETY REPORTS

Bartholomew County Medical Society members held a meeting at the Bartholomew County Hospital in Columbus, on July tenth. The eight members present discussed current business matters.

Shelby County Medical Society members held their annual picnic at the summer home of Dr. P. R. Tindall, on Flat Rock River. Approximately forty members and guests attended this event. A dinner was served, followed by outdoor recreation and card playing.

Warrick County Medical Society members met at the Boonville Legion Home on June twelfth. The guest speaker for the meeting was Dr. W. Russell Springstun, of Evansville, whose subject was "Atypical Virus Pneumonia." Ten members attended the meeting.

FOR WIVES ONLY!

Have you reminded your husband to make hotel reservations for October 29, 30, and 31, 1946, for the annual session of the Indiana State Medical Association, in Indianapolis? Or better still, make the reservations for him.

(P.S. We knew that you men would read this, too.)

WOMAN'S AUXILIARY to the Indiana State Medical Association

President ..... Mrs. Samuel J. Petronella
President-elect ..... Mrs. A. W. Ratcliffe
Corresponding Secretary ..... Mrs. D. A. Eisenberg
Treasurer ..... Mrs. Wendell Kelly
Press and Publicity ..... Mrs. Otto H. Bakemeier

CLARK COUNTY

The Woman's Auxiliary to the Clark County Medical Society sponsored the Baby Contest for the Jeffersonville Park Memorial Fund picnic, at Playsquare, on July fourth.

DELAWARE-BLACKFORD COUNTIES

Mrs. J. C. Silvers was hostess to the Delaware-Blackford Medical Auxiliary at her home on Orchard Lane, May twenty-second. Mrs. William Quick was elected president.

ELKHART COUNTY

The Elkhart County Auxiliary held a dinner meeting at the Christiana Country Club, north of Elkhart, in May.

FLOYD COUNTY

On May tenth the Floyd County Auxiliary met for a luncheon meeting at the New Albany Country Club. After the business meeting a musical program was presented by the Mothers' Chorus, under the direction of Mrs. Clarence Parr.

LAKE COUNTY

The Spa near Michigan City was the scene of a gala luncheon and program for the closing meeting of the Lake County Auxiliary. A book review, "David the King," by Gladys Schmitt, was given by Mrs. Milton Rubin, and a humorous reading by Mrs. Jess Grissom. Both ladies are members of the auxiliary.

MARION COUNTY

The convention chairman of the Woman's Auxiliary to the Indiana State Medical Association wishes to remind you to keep the dates, October 29 and 30, open for the convention to be held in Indianapolis on those two days, and to please make your reservations immediately at the hotels. Mrs. Emmett Lamb and her committee have planned two most entertaining and delightful days and evenings for the state auxiliary members.

VIGO COUNTY

The Woman's Auxiliary to the Vigo County Medical Society held its last meeting of the year on May thirteenth, at Hotel Deming; with a luncheon and installation of officers.

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TUMORS OF THE NOSE AND THROAT*

FREDERICK A. FIGI, M.D.†

ROCHESTER, MINNESOTA

Tumors of the nose and throat are not common, but they occur often enough to furnish a continuous challenge for the rhinolaryngologist. Consideration of these neoplasms constitutes only a small part of the practice of most specialists in this field; yet it is essential that these practitioners be familiar with the cardinal symptoms, clinical findings, and serious possibilities of these lesions, especially those of the malignant group. All too frequently one sees the tragedies resulting from delay in recognition and in the institution of proper treatment in such cases. The element of time often is the chief factor in determining whether removal of a neoplasm in this situation can be effected by means of a conservative type of operation or will necessitate a mutilating procedure; also, and more important, whether treatment is likely to be curative or only palliative.

A number of different types of benign and malignant tumors occur in the nose. Most common among the benign growths are papillomas, fibromas, angiomas, cysts, chondromas, and osteomas. Mucous polyps of the nasal fossae which are not true neoplasms but rather the result of a chronic inflammatory process will not be considered here. Depending on their size and situation, tumors of the nose may be entirely asymptomatic. More frequently they produce varying degrees of nasal obstruction and at times hemorrhages and external deformity. They may range in size from small, inconspicuous lesions to masses filling the entire nasal fossa and one or more of the accessory sinuses as well. As a result of pressure absorption of bone a benign tumor originating in the nasal fossa may extend into the adjacent sinuses, and vice versa.

These tumors vary greatly in appearance, color, texture and vascularity, and in the extent of their attachment. While the history and findings may strongly suggest the nature of the neoplasm, an accurate diagnosis must usually be based on microscopic study.

Their treatment is determined by the size, situation, and nature of the growth and by the age and general condition of the patient. Small, readily-accessible tumors may be removed with forceps and their attachment cauterized. As a rule large growths are better electrocoagulated or, if pedunculated, removed with a snare. Approach is usually made through the nares, but in the case of large neoplasms that are not accessible by this route other means of exposure are required. Local anesthesia will suffice when a well-localized lesion is to be eradicated, but for large tumors here as well as in most of the rest of the upper part of the respiratory tract, with the exception of the hypopharynx and larynx, intratracheal anesthesia is desirable if not absolutely essential.

Papillomas of the nose occur most often about the columella or low on the anterior portion of the septum. At times these thicken at the base and malignant change may be present. Fibromas may spring from the septum or from the inferior or middle turbinate and may produce a mass of considerable size in the nose and the nasopharynx.

* Read before the Anatomical and Clinical Postgraduate Course given by the Indiana University School of Medicine, at Indianapolis, on April 14, 1946.

† From the Section on Laryngology, Oral and Plastic Surgery, Mayo Clinic, Rochester, Minnesota.

These may occur at any age. The more serious fibromas of the nose are those of the juvenile basal type, which usually arise in the vault of the nasopharynx and extend forward from this region into the nasal fossae. These will be considered among the tumors of the nasopharynx. Both capillary and cavernous hemangiomas may involve either the exterior or the interior of the nose. Some of these hemangiomas of the cavernous type springing from high up in the nasal fossae produce recurring hemorrhages and obstructive symptoms and clinically simulate highly malignant neoplasms. In some instances, especially when they occur among elderly patients, only microscopic study will permit differentiation. Dermoid cysts, which usually form on the bridge of the nose, often extend down into the septum and may be limited to this structure. Their removal is at times difficult and some deformity may follow. Osteomas occur more frequently in the accessory sinuses than in the nasal fossae. They vary greatly in hardness, at times being extremely dense and so large that they cannot be delivered through the nostrils.

The majority of malignant tumors presenting in the nasal fossae are the result of extension of neoplasms originating in the maxillary sinuses, ethmoid cells, or nasopharynx. However, a small group of malignant lesions develop primarily in the nasal fossae. Most commonly encountered are squamous cell epitheliomas, adenocarcinomas, melano-epitheliomas, hemangio-endotheliomas, plasmocytomas and various types of sarcomas, including lymphosarcomas, myxosarcomas, fibrosarcomas, chondrosarcomas, and osteosarcomas. These neoplasms vary greatly in activity, but even the lesions that are highly malignant locally usually do not tend to metastasize until well advanced. In determining the type of treatment advisable in these cases, Broders' classification of malignant tumors in four grades, depending on their activity as evidenced by microscopic study, is extremely helpful. However, it must be borne in mind that the microscopic grade of a neoplasm is not necessarily an index of its radiosensitivity. In general, low grade lesions, which usually are radio resistant, are best electrocoagulated, while those of high grade are preferably treated by radiation. With proper therapy in a reasonably early stage many of these tumors can be entirely eradicated. The chief factors responsible for the unfavorable results seen in so many instances are the inaccessibility of the growth, undue delay in diagnosis, and improper or incomplete treatment.

Approach may be made to these tumors directly through the nasal meatus, through a lateral rhinotomy, a fronto-ethmoid incision, through the antrum, or by reflecting the upper lip and nose after incising along the superior labial fold inside the mouth. Lateral rhinotomy gives satisfactory access to tumors situated low in the nasal fossae, but a vulcanite nasal speculum often affords almost as good exposure, and removal by this route does not produce visible scarring. The fronto-ethmoid approach through an incision encircling the inner portion of the orbit and the root of the nose furnishes excellent exposure of lesions situated high in the nasal fossae and involving the frontal or ethmoid sinuses. The Denker operation is preferable when the antrum and nasal fossa are involved. The trans-antral approach is very useful for exposure of tumors in the lower part of the nasal fossae, especially posteriorly. Through these approaches electrocoagulation can be carried out and if deemed advisable radium points can be inserted as a supplementary measure. When the tumor is extensive and highly malignant, interstitially-applied radium together with radium packs or roentgen therapy will afford considerable palliation and at times is curative, depending to a great extent on the radiosensitivity of the neoplasm.

Active neoplasms that fill a large part of the nasal fossa and appear too extensive for operation at times will be found attached by only a small pedicle and wide destruction of the attachment of this pedicle will control the process.

Few benign tumors are encountered in the nasopharynx, pharynx, and tonsils. Most of these situated chiefly in the oropharynx encroach on the nasopharynx as well. Fibromas, neurofibromas, hemangiomas, papillomas, chondromas, aneurysms, and lipomas may occur here.

Juvenile basal fibromas of the nasopharynx comprise one of the most interesting groups of neoplasms encountered in the upper part of the respiratory tract. They present a definite life cycle and a characteristic clinical appearance. They arise most commonly in the vault or high on the posterior wall of the nasopharynx from the periosteum covering the basilar process of the occipital bone and the body of the sphenoid bone. They appear at about the age of puberty or slightly earlier than this and continue to be active until the age of approximately twenty to twenty-five years, at which time they tend to regress spontaneously. In some instances they are said to disappear completely although I have not personally observed such an instance. They usually appear as hard, rounded or lobulated, deep-red or grayish tumors occupying the upper portion of the nasopharynx and often extending into one or both nasal fossae as well. Their attachment is most frequently broad, sessile, and firm. Multiple secondary attachments to the pharyngeal or nasal wall may be present following unsuccessful attempts at operative removal. The tumor is covered with normal mucous membrane and tortuous vessels often stand out prominently on the surface.

Treatment of these tumors has undergone considerable change during the course of time. Prior to 1915 surgical procedures were resorted to almost exclusively. Such measures generally were attended by a high mortality rate and frequent recurrences among the patients who survived, necessitating repeated operations. Later radium therapy was employed. Since the beginning of 1924 my col-

leagues and I have used surgical diathermy with increasing frequency for this purpose and in most instances it has been supplemented with radium. Electrocoagulation often will eradicate entirely tumors of this type in a single sitting, a result which is rarely accomplished with radium, but it involves a greater hazard than irradiation.

The treatment of the remaining benign tumors of the pharynx depends to a great extent on their size. Small pedunculated papillomas, which most often spring from the tonsillar pillars and uvula, are readily destroyed with the diathermy electrode while the patient is under local anesthesia. Cavernous hemangiomas may be injected with sclerosing solution but often are better electrocoagulated. Lipomas and neurofibromas usually are well encapsulated and may be enucleated either through the mouth or through an external incision. Chondromas and osteochondromas arise from the transverse processes of one or more cervical vertebrae or the intervertebral disks and often are firmly fixed. The difficulty of completely removing them thereby is greatly increased and removal may not be feasible. An external approach is preferable in these cases. Any of these benign tumors may be of sufficient size to necessitate preliminary tracheotomy prior to exploration. Ligation of the external carotid artery greatly facilitates their removal.

The possibility of a diffuse, smooth-surfaced tumor of the pharynx being an aneurysm must always be borne in mind. This holds true even though no expansile impulse is either visible or palpable. Aneurysm of the internal carotid artery is occasionally encountered in this situation and bold incision of a pharyngeal mass under the mistaken impression that it was a benign tumor or an abscess has induced a fatal hemorrhage in more than one instance. In case doubt exists as to the nature of a mass in the throat it is advisable to insert a fine needle obliquely and attempt aspiration.

Malignant tumors of the nasopharynx occur more frequently than generally is supposed. The majority of these tumors are highly active squamous cell epitheliomas and lymphosarcomas. Although they may develop in any part of the nasopharynx, they most commonly originate in, or adjacent to, the fossa of Rosenmüller. Here they are in close proximity to a number of important structures, including the eustachian tube and several of the cranial nerves. Through involvement of these they produce a characteristic symptom complex, the chief features of which are pain, deafness, tinnitus, diplopia, and the presence of a mass in the neck. The pain is of a continuous aching, burning, or boring character, unilateral, worse at night than in the daytime, and usually situated deep in the temporal or parietal region or back of the eye. Symptoms referable to the ear result from encroachment on the eustachian tube or its orifice. Diplopia is usually due to external rectus palsy resulting from involvement of the sixth cranial nerve. A metastatic node in the upper cervical region may be the first evidence of trouble that attracts the patient's attention. As malignant neoplasms of the nasopharynx often do not produce symptoms referable to the nose and throat, they commonly are overlooked until well advanced.

Because of the inaccessibility of these tumors, their activity, the difficulty of accurately determining their extent, and their tendency to metastasize early, irradiation is the treatment of choice. Operation rarely is indicated for removal either of the primary lesion or of the regional lymphatics. Roentgen therapy or radium packs are used externally over the head and neck, and radium tubes on a pliable applicator are placed directly in contact with the tumor in the nasopharynx. Palliation only is likely to be obtained, although the growth can often be held in check and the patient kept in comparative comfort for several years. In a few instances my colleagues and I have observed complete arrest of the disease for periods ranging from eight to ten years. Fractional roentgen therapy appears especially effective in this connection.

Malignant tumors of the oropharynx include high-grade squamos cell epitheliomas, lymphosarcomas, fibrosarcomas and chondrosarcomas, and also slow-growing adenocarcinomas. Bilateral lymphosarcomas of the tonsils may occur. Most of the malignant tumors in this situation present a short history and the squamous cell epitheliomas usually cause severe pain. Lymphosarcomas and sarcomas of other types are likely to produce less discomfort than squamous cell epitheliomas. Adenocarcinomas of mixed tumor type, being encapsulated and very slowly progressive, commonly are symtomless until they attain considerable size. These latter tumors are best enucleated either through the mouth or externally. The squamous cell epitheliomas, if well localized, should be electrocoagulated, and this treatment should be supplemented with radiation. Squamous cell epitheliomas that are not well localized, as well as the remaining active neoplasms of the pharynx, are irradiated.

The malignant tumors of the base of the tongue and hypopharynx are chiefly highly malignant squamous cell epitheliomas, lymphosarcomas, and adenocarcinomas. Irradiation is the treatment of choice in the majority of these cases, for the same reasons mentioned in connection with neoplasms of the nasopharynx. As a rule, implantation of radon seeds or radium element points into the primary lesion is preferable to the direct application of radium to its surface, because of the greater accuracy and efficiency of the former method. Infrequently tumors on the base of the tongue are encountered sufficiently early to permit electrocoagulation following exposure with modified laryngeal suspension. This treatment is supplemented with implantation of radium points. If the degree of malignancy is not too great, block dissection of the lymphatic structures on the same side of the neck is advisable. A number of five-year and a few ten-year cures have been secured in this group,

both with irradiation and with the surgical measures outlined.

Tumors of the larynx constitute some of the most interesting and at the same time the most serious of the pathologic conditions that affect this structure. A number of different types of benign and malignant neoplasms occur. Early recognition and proper treatment of these growths are extremely important since the likelihood of cure in cases of malignant tumor is directly dependent on these two factors.

The possibility that a tumor of the larynx is present must be considered in every case in which chronic hoarseness is encountered. These tumors may occur at any period of life, but are most common in middle age. With few exceptions those which occur among patients less than twenty years of age are benign. Males of all ages are much more frequently affected by benign tumors of the larynx than are females, a rule which also holds true for malignant lesions of this structure. The most common benign laryngeal growths are, in the order of their frequency, papillomas, myxomas, cysts, inflammatory masses, epithelial hyperplasia, leukoplakia, angiomas, and amyloid tumors. Fibromas, chondromas, and xanthomas occur rarely. Many of these tumors may be dealt with by means of indirect laryngoscopy, but, when feasible, suspension and removal is the treatment of choice. At times the extent of these tumors renders thyrotomy essential for their exposure and excision.

The great majority of malignant tumors of the larynx are squamous cell epitheliomas although fibrosarcomas, hemangio-endotheliomas and adenocarcinomas are also encountered. In general, these lesions metastasize late and are best treated with radical operation, as only through an open operation can the majority of them be clearly visualized and rendered accessible. At times, however, the nature, activity, situation, and extent of the lesion, or the age and general condition of the patient, render radical surgical measures inadvisable. Growths situated in the supraglottic region, especially those springing from the epiglottis, are commonly inactive in type and often may be destroyed readily with diathermy, using direct, indirect, or suspension laryngoscopy. Generally, the prognosis following such removal is good. However, pharyngotomy often is more satisfactory for dealing with many lesions in this region. Tumors which involve the epiglottis and extend posteriorly along the aryepiglottic folds and laterally into the pyriform fossae can be taken care of through a subhyoid approach. On the other hand, when there is limited involvement of one aryepiglottic fold with extension onto its outer aspect, or when there is involvement of the epiglottis and base of the tongue, lateral pharyngotomy is preferable, after removal of part of the thyroid ala and, if necessary, a portion of the hyoid bone. In cases in which the growths are extensive, preliminary tracheotomy greatly lessens the risk of this operation as well as of other radical laryngeal procedures.

Laryngofissure or thyrotomy is indicated in cases of laryngeal carcinoma in which the tumor is inactive and freely movable, or if the tumor is active it must be recognized early and be well localized. After the larynx is opened in or adjacent to the midline, the lesion is excised and the wound cauterized. In properly-selected cases results as regards control of the malignant process are extremely satisfactory with laryngofissure, the prognosis for five-year cure being a fraction more than 82 per cent.

When the malignant process extensively involves both sides of the larynx, and especially when it is active or the lesion is fixed, complete removal of the larynx alone offers a reasonable chance of controlling the disease. The operation has been perfected during the course of years until at present the mortality rate is very low considering the extent of the procedure. It is best carried out with the patient under cervical block anesthesia and usually in a single stage. Even though most laryngeal carcinomas are highly malignant, the operation offers slightly better than a 56 per cent prognosis for five-year cure providing the tumor has not spread beyond the larynx.

While laryngectomy permanently deprives the patient of his normal voice, a large percentage of these individuals are able to develop a good pharyngeal or esophageal voice, and the remainder acquire satisfactory speech with the use of one of the mechanical contrivances made for this purpose. The exposed tracheal opening causes comparatively little inconvenience, and such patients seem no more subject to infections of the respiratory tract than normal persons. Providing there is no recurrence of the neoplasm, longevity does not appear to be affected.

QUESTION USEFULNESS OF QUARANTINE AGAINST POLIOMYELITIS

Usefulness of quarantines established by some states to prevent the spread of poliomyelitis is held "highly questionable" by *The Journal of the American Medical Association*. In the July 27 issue, *The Journal* says in an editorial:

"This year, as in previous years, some sections of the country have developed an exceptionally high incidence of poliomyelitis. A few cities in southern Florida were involved in this manner. One of the neighboring states considered the establishment of a quarantine against Florida residents. Georgia actually imposed such a quarantine against all persons coming from the former state, even including Pensacola, which is 402 miles from the nearest city in which there has been an outbreak of poliomyelitis that could possibly be considered as epidemic in nature. The usefulness of this interstate quarantine is highly questionable. The overwhelming consensus of authorities in epidemiology and public health is that such interstate quarantine does not serve any useful purpose in preventing the spread of poliomyelitis. In the absence of more specific knowledge on the methods of spread of the poliomyelitis virus than is now available, state quarantine can only be considered reminiscent of the old practice of shot-gun quarantine against yellow fever before learning the role of the yellow-fever-bearing mosquito."

PRACTICAL APPLICATION OF THE RH FACTOR IN CONGENITAL HEMOLYTIC ANEMIA OF THE NEWBORN (ERYTHROBLASTOSIS FETALIS), HABITUAL ABORTION, AND BLOOD TRANSFUSIONS

J. L. HAYMOND, M.D.*

A. S. GIORDANO, M.D.*

SOUTH BEND

A working knowledge of the Rh factor of the blood is now known to be essential in the proper management of the following conditions:

1. Congenital hemolytic anemia of the newborn (formerly known as erythroblastosis fetalis, icterus gravis, edema of the newborn, and congenital anemia).

2. Habitual or repeated abortions or miscarriages.

3. Transfusion reactions, particularly in pregnant women and in persons receiving repeated blood transfusions for various causes.

CONGENITAL HEMOLYTIC ANEMIA OF THE NEWBORN

Congenital hemolytic anemia (erythroblastosis fetalis) is a condition occurring in newborn infants, characterized clinically by jaundice, edema, enlargement of the spleen and liver, hemorrhagic tendencies, and various other manifestations of hemolytic anemia, such as the appearance of numerous immature red blood cells (erythroblasts) in the peripheral blood and bilirubinemia with indirect positive van den Bergh reaction. The incidence has been stated to vary from about one in every 150 to one in every 400 newborn, and the severity of the disease is variable; however, the mortality without treatment is about 50 per cent.[1]

In 1940 Landsteiner, who is correctly known as the father of our present concept of blood grouping, initiated the research studies which have led to the discovery that the cause of congenital hemolytic anemia is incompatibility in a newly-discovered blood factor between mother and fetus in intrauterine life. Landsteiner was assisted in the early work on Rh by Wiener, who deserves much of the credit for the fundamental scientific research in this field.

This discovery illustrates the importance of elementary biological research in medical science. In 1937 Landsteiner and Wiener were studying the use of animal blood in the preparation of certain testing sera in a search for new factors in human blood. They injected the blood of a Rhesus monkey into a rabbit, later procured the rabbit's blood serum, and noted that it not only agglutinated monkey's red blood cells, but also about 85 per cent of Caucasian red blood cells. This new factor was designated as the Rh factor (Rhesus monkey factor).[2] The new knowledge was first applied clinically by Wiener and Peters[3] in a study of blood transfusion reactions which were shown to be due to iso-immunization to the Rh factor as a result of transfusing Rh positive blood into an Rh negative patient. Levine and his collaborators[4] noted that intra-group transfusion reactions occurred with exceptional frequency in women who had had stillbirths or infants with congenital hemolytic anemia, and this suggested that iso-immunization in pregnancy might be the basis of the disease.

The complete explanation for the practical application of this knowledge is as follows: the population in general is divided into four standard groups which are concerned in ordinary blood-typing procedure: Type 1, or AB, 10 per cent; Type 2, or A, 40 per cent; Type 3, or B, 7 per cent; and Type 4, or 0, 43 per cent. In addition there are other known blood factors in human beings; namely, M, N, P, and Rh. The Rh factor is the most important from a clinical point of view and is concerned in the problem of congenital hemolytic anemia of the newborn. About 85 per cent of the Caucasian population has been found to be Rh positive, and 15 per cent Rh negative. There is a distinct racial variation, as shown by the fact that Negroes are 91.9 per cent Rh positive; Asiatic Indians, 92.9 per cent; Chinese, 98.5 per cent; Mexican Indians, 100 per cent; Japanese, 98.7 per cent; and Filipinos and Indonesians, 100 per cent.[5] The Rh factor is inherited as a simple Mendelian dominant characteristic. Rh negative individuals are always homozygous; Rh positive individuals may be either homozygous or heterozygous. When both of the parents are Rh negative, all of the children will be Rh negative. When there is an Rh positive father of the so-called "homozygous type" and an Rh negative mother, the children are all Rh positive. When there is an Rh positive father of the so-called "heterozygous type" and an Rh negative

* From South Bend Medical Laboratory, South Bend, Indiana.

[1] Potter, E. L.: The Present Status of the Rh Factor, *Am. J. Dis. Child.*, **68**:32-58, (July) 1944.

[2] Landsteiner, K., and Wiener, A. S.: An Agglutinable Factor in Human Blood Recognized by Immune Sera for Rhesus Blood, *Proc. Soc. Exper. Biol. & Med.*, **43**:223, (Jan.) 1940.

[3] Wiener, A. S., and Peters, H. R.: Hemolytic Reactions Following Transfusion of Blood of the Homologous Group, with Three Cases in Which the Same Agglutinogen was Responsible, *Ann. Int. Med.*, **13**:2306-2322, (June) 1940.

[4] Levine, P.; Katzin, E. M.; and Burnham, L.: Iso-immunization in Pregnancy; Its Possible Bearing on the Etiology of Erythroblastosis Fetalis, *J.A.M.A.*, **116**: 825-827, (Mar. 1) 1941.

[5] Wiener, A. S.: Rh Factors in Clinical Medicine, *J. Lab. & Clin. Med.*, **30**:957-976, (Nov.) 1945.

mother, 50 per cent of the children will be Rh positive.[6]

During pregnancy normally there is no intermingling of the blood of the mother and fetus. Nevertheless, under certain conditions the baby's blood may escape into the mother's circulation. If the baby is Rh positive, the red blood cells containing the Rh agglutinogen, when circulating in the blood stream of an Rh negative mother, would stimulate the mother's body cells to produce antibodies against the Rh factor, forming anti-Rh agglutinins and hemolysins which possess the property of agglutinating and hemolyzing the baby's Rh positive red blood cells. These antibodies pass the placental barrier and appear in the baby's blood stream. As the term of pregnancy progresses, the titre of Rh agglutinins and hemolysins increases in the mother's circulation and destruction of the baby's red blood cells occurs, thus calling upon bone marrow of the baby to produce more red blood cells for replacement. This process in the baby continues until the demand for mature red blood cells becomes greater than the supply, and immature or nucleated red blood cells appear in the peripheral circulation, thus the origin of the term erythroblastosis. This hemolytic destruction of the baby's red blood cells may be of various degrees of rapidity, so that the baby may die before pregnancy reaches term or may be born dead at term. Therefore, all cases of habitual abortion or repeated miscarriages should be investigated to determine whether an Rh incompatibility exists in the parents. In living babies a hemolytic crisis with resulting severe anemia may occur shortly after birth or may be manifested at any time up to the fourteenth day after birth. Jaundice, which is the most prominent symptom, is due to the rapid hemolytic destruction of the baby's red blood cells. This leads to the liberation of large amounts of bilirubin, which the liver is unable to excrete as rapidly as formed, and jaundice results. Simultaneously, a severe anemia may occur, and this factor may lead to the death of the baby by anoxia of the vital organs.

Although the mating of the Rh negative woman with Rh positive man occurs statistically in about one out of ten marriages, congenital hemolytic anemia of the newborn affects about one in 250 newborn infants, according to Wiener.[5] This indicates that only about one in 25 Rh negative women become sensitized when bearing Rh positive fetuses, and this is explained by variations in antigenicity of the Rh positive cells of the fetus, as well as the great individual variations in ability of the mother's body cells to respond to the stimulus by the formation of anti-Rh antibodies. The first-born is rarely affected, because it takes at least one pregnancy, and sometimes more, before a sufficient degree of sensitization develops. As multiple pregnancies are not frequent in this modern age, many potential cases are missed. In most of the rare cases where the first-born was affected a medical history reveals that the woman had previously received a transfusion of Rh positive blood;[7] however, we have observed two cases in which no previous history of pregnancy or transfusion could be elicited. This served to emphasize the importance of Rh tests before giving blood transfusions to all females from infancy, for such a transfusion could ruin a woman's chances of having a normal child through the introduction of a type of blood which would stimulate the production of anti-Rh substances.[8]

Over 90 per cent of all women with infants suffering from congenital hemolytic anemia are Rh negative. The occasional occurrence of hemolytic disease when the mother is Rh positive is due to (1) subtypes of Rh factor; (2) Hr factor; and (3) A or B factors.

SUBTYPES OF Rh

The immune serum produced by immunization of a rabbit with the blood cells of a Rhesus monkey will divide the population into two types: Rh positive, and Rh negative. Subgroups were first recognized when it was shown that serum from Rh negative patients sensitized to the Rh factor varied in the type of Anti-Rh agglutinins produced, and on this basis eight Rh blood types are recognized. For the white population of New York City, these are: Rh negative, 14.5 per cent; Rh_1, 52.5 per cent; Rh_2, 15.7 per cent; Rh_1, Rh_2, 13.1 per cent; Rh_0, 2.4 per cent; Rh′, 1.1 per cent; Rh″, 0.7 per cent; Rh′Rh″, 0.02 per cent.[5] When the mother and father are of different Rh positive subgroups, iso-immunization in pregnancy may occur.[9, 10] With the above information in mind, it is well to emphasize that some commercial anti-Rh testing sera may not agglutinate cells of all of the subtypes of Rh, and in this way an individual may be erroneously labeled as Rh negative.

THE Hr FACTOR

Levine and Javert[11] first reported that they had detected in the serum of an Rh positive mother of an erythroblastotic fetus an antibody which had the properties of agglutinating Rh negative blood cells, the exact reverse of the usual result. Because of this property of a serum, it was designated as Hr, the reverse of Rh, and the corresponding agglutinin

[6] Frohman, I. G.: Rh Heterozygous Mendelian Transmission in a Large Family, *Am. J. Clin. Path.*, **15**:471-472, (Oct.) 1945.

[7] Levine, P.: Prevention of Unintentional Iso-immunization of Rh-Negative Female Population, *J.A.M.A.*, **128**:946, (July 28) 1945.

[8] Levine, P., and Waller, R. K.: Erythroblastosis Foetalis in the First-born, *Blood*, **1**:143-155, (Mar.) 1946.

[9] Waller, R. K.; Levine, P.; and Garrow, I.: Case Caused by Immunization of Rh-Positive Mother by Rh Factor, *Am. J. Clin. Path.*, **14**:577-581, (Nov.) 1944.

[10] Wiener, A. S.: Role of Subtypes of Rh, *Am. J. Clin. Path.*, **14**:52-60, (Jan.) 1944.

[11] Levine, P.; Burnham, L.; Katzin, E. M.; and Vogel, P.: The Role of Iso-immunization in the Pathogenesis of Erythroblastosis Foetalis, *Am. J. Obst. & Gynec.*, **42**:925-937, (Dec.) 1941.

as anti-Hr. This testing serum reacted with 80 per cent of Rh negative bloods. An occasional case of iso-immunization to this factor has been reported.

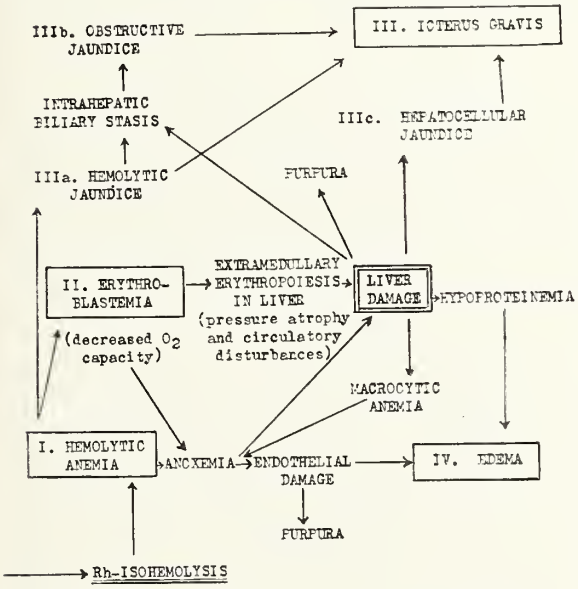
A & B FACTORS

Some cases of congenital hemolytic anemia have been attributed to iso-immunization in the A, B, and O factors.[12] In this instance the mother develops a very high titre of anti-A or anti-B agglutinins which react to produce hemolytic anemia in the baby in the same manner as anti-Rh agglutinins. It is not clear why the A, B, and O factors so rarely cause trouble, considering that the maternal serum frequently contains natural iso-agglutinins anti-A and anti-B, and that A and B factors are far more potent antigens than Rh.

BLOCKING ANTIBODIES

In addition to the regular anti-Rh agglutinins which are detected by mixing the patient's serum with known Rh positive type O blood cells, it has been shown by Wiener that anti-bodies designated as "blocking antibodies" may be present. These must be demonstrated by a special technique.[13, 14]

FIGURE I



"Pathogenesis of fetal erythroblastosis. Principle: Rh positive husband of Rh negative woman transmits the Rh factor to the fetus. Rh antigenic substances pass from Rh positive fetus through placenta and produce in mother Rh antibodies. The latter pass from mother to fetus through placenta, act in the fetus as hemolytic agents, and start the sequence of interlocking pathologic changes as presented in this chart."

[12] Polayes, S. H., and Ohlbaum, C.: Erythroblastosis Fetalis Unrelated to the Rh Factor. Report of Nine Cases Suggesting Iso-immunization of Group "O" Mothers by "A" Children, *Am. J. Clin. Path.*, **15**:467-470, (Oct.) 1945.

[13] Wiener, A. S.: A New Test (Blocking Test) for Rh Sensitization, *Proc. Soc. Exper. Biol. & Med.*, **56**:173-176, (June) 1944.

[14] Wiener, A. S.: Conglutination Test for Rh Sensitization, *J. Lab. & Clin. Med.*, **30**:662-667, (Aug.) 1945.

Blocking antibodies explain, in part, the absence of anti-Rh agglutinins in about 50 per cent of Rh negative women who have delivered erythroblastotic fetuses. With improved technique this incidence has been reduced, as shown by Diamond[15] and our own experience.

PATHOLOGY

The pathologic manifestations of congenital hemolytic anemia of the newborn are a direct result of excessive destruction of erythrocytes and an attempt on the part of the body to compensate for this loss.

The interrelationship of the various changes are clearly demonstrated by the diagram in Figure I, taken from Davidsohn.[16]

At necropsy the principal findings are foci or erythropoiesis in abnormal locations and deposits of blood pigment in liver, spleen, and kidneys. Causes of death are anoxia, irreversible liver damage, hemorrhagic manifestations, and brain damage consisting of nuclear degeneration which results in the so-called "kernicterus."

CLINICAL DIAGNOSIS OF COGENITAL HEMOLYTIC ANEMIA OF THE NEWBORN

History: As the disease does not usually occur in an unsensitized mother in her first pregnancy, a history of previous blood transfusions, previous miscarriages, or previous baby jaundiced at birth or shortly after birth is of great importance.

Symptoms: The three principal symptoms of which any one may predominate are (a) icterus, (b) edema, and (c) anemia.[17] Jaundice is the most frequently seen clinical manifestation. Some cases may show striking pallor due to anemia without jaundice, because hemolysis has occurred slowly—liberating bilirubin in amounts which the liver can excrete readily. Edema in the newborn and hemorrhagic manifestations are not so frequently observed and are associated with a high mortality. The liver and spleen may be enlarged, but this is not a constant detectable feature in our experience.

Laboratory Findings: A final definite diagnosis depends upon the laboratory findings. In about 90 per cent of the cases the mother will be Rh negative, and the child and father Rh positive. However, the fact that mother and father are both Rh positive does not exclude congenital hemolytic anemia, because of the incidence of the Rh positive subtypes, as well as those cases explained by iso-immunization to the A-B factors and the Hr factor. From a laboratory standpoint the demonstration of anti-Rh agglutinins in the blood of the mother is the most important diagnostic feature. However, these antibodies can be demonstrated in only about

[15] Diamond, L. K., and Abelson, N. M.: The Detection of Rh Sensitization: Evaluation of Tests for Rh Antibodies, *J. Lab. & Clin. Med.*, **30**:668-674, (Aug.) 1945.

[16] Davidsohn, I.: Fetal Erythroblastosis, *J.A.M.A.*, **127**:633-638, (Mar. 17) 1945.

[17] Diamond, L. K.; Blackfan, K. D.; and Baty, J. M.: Erythroblastosis Foetalis, *J. Pediat.*, **1**:269-309, (Sept.) 1932.

one-half of the cases by ordinary technique, and the titre often does not parallel the severity of the disease. The antibodies may be in low titre or absent from the maternal serum at the time of the birth of the child. Thus, the titre may or may not be elevated during pregnancy and puerperium, and the presence of the blocking antibodies must be investigated. The titre rises following delivery, and it has been shown that the best time to test for anti-Rh agglutinins in the mother's blood is about ten days after delivery.[16]

Even though the serological diagnosis is the more specific, a complete blood count on the baby is more valuable in making the immediate decision as to the diagnosis and treatment. The hemolytic anemia results in a stimulation of the bone marrow with the appearance of nucleated or immature red blood cells (erythroblasts) in the blood stream, and they are found in the blood smear. However, the erythroblasts may not be present in increased numbers at the time the examination is made, and their absence does not rule out congenital hemolytic disease. Thus, the term erythroblastosis fetalis is a misnomer. The demonstration of marked diminution in the red cell count and hemoglobin determination is of great diagnostic importance and a guide for treatment. The white blood count is elevated and a leukemoid blood picture may exist. Serum bilirubin will always be elevated, and the van den Bergh reaction will be the indirect positive type early in the disease.

DIFFERENTIAL DIAGNOSIS

In the differential diagnosis the following conditions should be considered: icterus neonatorum or physiological jaundice of the newborn, congenital malformation of the heart, congenital stenosis of the bile ducts, hemorrhagic disease of the newborn, antenatal and postnatal infection, and congenital syphilis.

ROUTINE MANAGEMENT

We have witnessed several instances in which congenital hemolytic anemia has been confused with physiological jaundice of the newborn. In order to prevent the occurrence of such diagnostic errors, the following recommendations for routine management of all jaundiced newborn infants were made and adopted by local hospitals:

(1) A complete blood count on the baby and an Rh typing on the mother are to be performed immediately when a definite icteric tinge is recognized by the physician or nurse, regardless of lack of other symptoms.

(2) If the laboratory and clinical findings confirm the diagnosis of congenital hemolytic disease and anemia exists below the level of 3.5 million red blood cells per cmm., an immediate transfusion with compatible blood is to be given in adequate quantities by the intravenous route. We consider that 3.5 million red blood cells per cmm., or 65 per cent (10 Gm.) hemoglobin, is the critical point below which transfusion should be given, since unpredictable hemolytic crises do occur.

The following sources of blood for transfusions are suitable for cases of congenital hemolytic disease:

(1) A type O Rh negative donor. This is the type of blood which we use routinely and which works satisfactorily in almost all cases. (It is said that this type of blood is comparable to the skeleton key which fits most locks.) A list of these donors is maintained in our hospitals.

(2) The washed red blood cells of the mother resuspended in saline. This is said to be the most satisfactory source of red blood cells, but is technically much more difficult to prepare. (This is said to be comparable to the master key which fits all locks).

(3) Rh positive blood may be used if neither of the other is available, but the beneficial effect will be rapidly lost due to hemolysis (and rapid) of the cells. The transfusions must be repeated frequently to maintain a satisfactory blood level.

No compatibility test is necessary if mother's washed red blood cells are used for the transfusion, as newborn infants do not possess agglutinins against the mother's red blood cells. When type O Rh negative blood is used, compatibility tests can also be omitted, as this type is the "universal donor."

It is important that an adequate quantity of blood be administered promptly and repeated as necessary if these infants are to be saved. The initial dose should not be less than 10 cc. of whole blood or resuspended mother's red blood cells per pound of body weight of the infant. Rapid administration of blood must be avoided and erythrocyte count should not exceed 6 million per cmm. The recommended rate of administration is 1 cc. per minute by the gravity method.

The blood must be given by the intravenous route, as it has been shown that intramuscular or subcutaneous injections are of no benefit. A specialist should be called to give the transfusion if difficulty is encountered. The transfusion of the infant in congenital hemolytic anemia is an emergency procedure and should be performed with the same promptness as any emergency surgical procedure. It has been demonstrated conclusively that if adequate quantities of blood are given, infant mortality is markedly reduced.

The number of transfusions must be controlled carefully by laboratory studies. As hemolytic crises may occur any time up to the fourteenth day after birth, and a more gradual hemolytic process may persist for some time after that, the red blood count and hemoglobin should be checked frequently to control the therapy accurately. It has been shown that these infants may completely break down all the blood in their bodies except that which has been given by transfusions, thus proving the life-saving powers of properly-given transfusions.

The treatment should include glucose and vitamin K to combat the liver damage. Choline chloride has

also been recommended for this purpose. These babies should not be breast fed by the mother as the anti-Rh antibodies appear in the milk.[18]

In adhering to this program of routine testing of jaundiced babies, in a period of one year in a 225 bed hospital (St. Joseph's Hospital of South Bend), of the 1,277 deliveries, 56, or 4.3 per cent, of the babies were jaundiced, and 12, or 21.4 per cent, of the mothers of jaundiced babies were Rh negative. Congenital hemolytic disease was recognized in eight cases, or 14.3 per cent, of the jaundiced babies, or 66 per cent of the jaundiced babies whose mothers were Rh negative. (This is an incidence of one in 159 deliveries.)

Of the eight cases observed by us, two required no treatment as there was no anemia; two of the cases required intensive transfusion therapy and recovered; and the remaining four cases died without treatment by transfusion therapy. One case died on the third day of life and was not transfused because no anemia was found by laboratory examination. Autopsy revealed severe liver damage. One died forty hours after birth, and autopsy revealed pulmonary congestion, edema, and atelectasis. One died two hours after delivery by induced labor at the eighth month of gestation, and autopsy revealed congenital heart disease. One child was born dead and no autopsy was performed.

Jaundice was present in six of the eight cases, and of the two cases in which jaundice was lacking, one child was born dead and the other died two hours after birth. In two of the living infants the jaundice was noticed on the first day of life; in two cases it was noted on the second day of life; in one case on the third day; and in one case on the fifth day. The infants selected for the routine examination were those in which a jaundice of definite perceptible degree was present and a clinical classification ranging from 1 to 4 plus was made, depending on the observed intensity of the jaundice. In two cases the degree of jaundice was classified as 1 plus, one case as 2 plus, and three cases as 4 plus. Serum bilirubin was not estimated routinely because of the technical difficulty of obtaining a specimen from a newborn infant. However, in one case the serum bilirubin on the sixth day of life was found to be 40.8 mg. with a negative direct van den Bergh reaction, and in this case the test aided in ruling out congenital stenosis of the bile ducts. Anti-Rh antibodies in the mother's serum were found in seven of the eight cases, and in the one further study of blocking antibodies was not made. Of twenty-seven additional Rh negative cases tested in this laboratory, anti-Rh antibodies were demonstrated in seventeen cases (63 per cent), titres ranging from 1:1 to 1:512. The presence of nucleated red blood cells in the blood smear was not found to be a dependable criterion in establishing the diagnosis, as an increased number of nucleated red blood cells was found in only four of the eight cases. Of these four cases two lived and two died (See Figure I).

Ideally an Rh typing should be performed on each pregnant woman before delivery to avoid the transfusion of Rh positive blood into an Rh negative female. As this has not been done in many hospitals for various reasons, we believe that the best alternative is to follow the plan of testing all jaundiced babies, as we have outlined. From an economic standpoint the performance of fifty-six tests with a yield of twelve cases would seem to justify this procedure. The clinical diagnosis of congenital hemolytic anemia is often made too late to render the most desirable form of intensive treatment to the baby; therefore, a routine procedure for the early recognition of these cases should be adopted by all hospitals.

Rh FACTOR IN HABITUAL ABORTION

Hunt[19] of the Mayo Clinic, from a study of twenty-five cases of repeated abortion and miscarriage, has concluded that the Rh factor is not of great importance as a common cause of such untoward terminations of pregnancy. Apparently the Rh factor becomes operative in this capacity only in the last half of gestation (after twenty-eight weeks). Endocrine deficiencies of function of pituitary, ovaries, and thyroid are probably of more importance in habitual abortion than the Rh factor. However, the possibility should be considered and all suspicious cases ruled out by the Rh test.[20] Artificial insemination may be employed, using an Rh negative male donor to secure a viable child.[21]

Rh FACTOR IN BLOOD TRANSFUSION REACTIONS

In the typical case of transfusion reaction due to Rh sensitization, an Rh negative recipient has received two or more transfusions of Rh positive blood over an interval of time sufficient to permit the development of antibodies.[22] If the recipient is a pregnant Rh negative woman who has been previously sensitized by an erythroblastotic fetus or by receiving previous transfusions of Rh positive blood, very severe reactions may occur, and death has occurred in some instances; so that it is recommended that the Rh test should be performed on all female patients of the childbearing age before an elective transfusion is given.[22, 23, 24] In this connection it should be remembered that severe hemolysis as a result of iso-immunization may occur

[18] Witebsky, E., and Heide, A.: Further Investigations on the Presence of the Rh Antibodies in Breast Milk, *Proc. Soc. Exper. Biol. & Med.*, **52**:280-281, (Apr.) 1943.

[19] Hunt, A. B.: Rh Factor in Repeated Abortion and Miscarriage, *Proc. Staff Meet., Mayo Clin.*, **20**:26-28, (Jan. 24) 1945.

[20] Cohn, T. D., and Cole, S. L.: Fetal Erythroblastosis and Habitual Abortion, *Am. J. Dis. Child.*, **68**:28-29, (July) 1944.

[21] Potter, E. L., and Willson, J. R.: Artificial Insemination as a Means of Preventing Erythroblastosis, *J.A.M.A.*, **127**:458-459, (Fed. 24) 1945.

[22] Diamond, L. K.: Medical Progress: Clinical Importance of the Rh Blood Type, *New England J. Med.*, **232**:447-450, (Apr. 19): 475-480, (Apr. 26) 1945.

without any demonstrable signs being exhibited by the patient, except that the transfusion does not elevate the red blood count and hemoglobin.[23]

ILLUSTRATIVE CASES

Case 1—A typical case with recovery. Baby M. L. V., a patient of Dr. O. Beardsley, was admitted to St. Joseph's Hospital, South Bend, on Sept. 16, 1945. The baby was intensely jaundiced at birth, and hemoglobin was 53 per cent (8 Gm.). The mother was Rh negative. One hundred cc. of Type O Rh negative blood was given immediately, and the hemoglobin rose to 109 per cent (16.3 Gm.) on the third day of life. On the thirteenth day hemoglobin had dropped to 76 per cent (11.4 Gm.), and a transfusion of 100 cc. of Type O Rh negative blood was given. Hemoglobin was 128 per cent (19.2 Gm.) after the transfusion, dropping to 99 per cent (14.9 Gm.) on the nineteenth day and remaining near that figure until discharge from the hospital on the thirty-third day of life.

Case 2—The differential diagnosis of congenital hemolytic anemia from congenital obstruction of the bile ducts with prolonged clinical course and later death. Baby J. Y., a patient of Dr. F. J. Vurpillat and Dr. K. T. Knode, was born at St. Joseph's Hospital, South Bend, on May 4, 1945. The baby was born by normal delivery and became intensely jaundiced on the third day. At this time the hemoglobin was 75 per cent (11.2 Gm.). The mother was Rh negative and the anti-Rh agglutinins were present in a titre of 1:4. One hundred cc of Type O Rh negative blood was given on the third day, and on the ninth day the hemoglobin was 128 per cent (19.2 Gm.). However, the intense jaundice persisted and the child frequently regurgitated his feedings. The stools were clay-colored and the test for urobilinogen was negative on five occasions, and showed traces of urobilinogen on three other occasions. The serum bilirubin on the sixth day of life was 40.8 mg. per cent with an indirect positive van den Bergh reaction, which is characteristic of hemolytic jaundice and differentiates it from an obstructive jaundice. The child improved symptomatically, but the jaundice persisted. On the twenty-fourth day the hemoglobin was 88 per cent (13.1 Gm.); the thirtieth day, 76 per cent (11.4 Gm.); and on the thirty-fourth day, 62 per cent (9.3 Gm.), at which time a blood transfusion was given. On the thirty-fifth day the hemoglobin was 99 per cent (14.8 Gm.); on the forty-seventh day a serum bilirubin was 3.9 mg. per cent and the van den Bergh reaction was direct positive. This illustrates very clearly that in the absence of hepatic damage an indirect positive van den Bergh reaction is diagnostic of hemolytic jaundice; but when hepatic damage occurs, even though the bilirubin is low, the reaction becomes direct positive. The child was released from the hospital on the fifty-eighth day in general good condition. Hemoglobin was 90 per cent (13.4 Gm.). Later he showed retardation of mental development and died at the age of six months. Autopsy was not obtained. Nuclear degeneration of the brain would have explained the mental retardation and death.

Case 3—A prolonged clinical course with recovery. Baby M. B., a patient of Dr. C. O. Joest and Dr. V. Christophel, born at St. Joseph's Hospital, Mishawaka, on October 21, 1945, was noticed to be jaundiced on the fourth day of life. The hemoglobin determination was not done until the eighth day, at which time the hemoglobin was 36 per cent (5.4 Gm.) and numerous nucleated red blood cells, as well as numerous immature white blood cells, were found on the smear. The mother was found to be Rh negative and anti-Rh antibodies were present in titre of 1:32. Ninety-five cc. of Type O Rh negative blood was given intravenously. On the tenth day of life the hemoglobin was 73 per cent (11 Gm.). On the twelfth day the hemoglobin dropped to 50 per cent, and another 100 cc. of blood was given by the intravenous route at what was considered a reasonably slow rate by the physician in charge. However, at the end of the transfusion the baby became cyanotic and experienced great respiratory difficulty. It is believed that this reaction was due to too rapid administration with an overloading of the circulation. On the fourteenth day the hemoglobin was 85 per cent (12.7 Gm.); on the sixteenth day, 74 per cent (11.1 Gm.); on the twenty-second day, 70 per cent (10.5 Gm.); on the twenty-fourth day, 60 per cent (9 Gm.). Due to the previous severe reaction no additional transfusions were given and a daily check of the hemoglobin revealed it to fluctuate between 53 and 60 per cent. The patient was released on the fiftieth day of life, "apparently in good condition," with a hemoglobin of 60 per cent (9 Gm.). At the age of four months hemoglobin was 76 per cent (11.4 Gm.) and development was normal.

Case 4—Case of congenital hemolytic anemia in which the mother was Rh positive, first pregnancy. Baby M., patient of Dr. J. A. Abel, was born prematurely, at seven months' gestation, at St. Joseph's Hospital, South Bend, on March 21, 1945. It was observed to have a mild jaundice at birth and died forty hours after birth with respiratory difficulty. Autopsy revealed congestion and edema of the lungs and beginning bronchopneumonia. There were erythroblastic foci in the various organs; however, liver and spleen were not enlarged. The mother was found to be Rh positive of a subgroup Rh' which constitutes 1.1 per cent of the population. No antibodies were demonstrated. This was the first pregnancy, and there was no history of a previous transfusion. A postmortem blood smear on the infant revealed numerous nucleated red blood cells.

[23] DeGowin, E. L.: Iso-immunity to the Rh Factor as a Cause of Blood Transfusion Reactions, *J. Lab. & Clin. Med.*, **30**:99-106, (Feb.) 1945.

[24] Unger, L. J., and Wiener, A. S.: Observations on Sensitization to the Rh Factor by Blood Transfusion, *Am. J. Clin. Path.*, **15**:280-286, (July) 1945.

Case 5—Fatal hemorrhagic manifestations. Baby F., a patient of Dr. D. A. Bickel and Dr. K. T. Knode, was born at Memorial Hospital, South Bend, on May 21, 1945, died one-half hour after a normal delivery, and was observed to show a mild jaundice. There were numerous nucleated red blood cells in the blood smear taken before death. The mother was Rh negative; the father, Rh positive; and there was one living brother who was Rh positive. The mother showed anti-Rh agglutinins titre of 1:32 on the day after delivery, and a titre of 1:128 twenty days after delivery. Autopsy of the baby revealed the abdominal cavity to contain a quantity of free blood. There were numerous petechial hemorrhages on the skin surfaces. The liver and spleen were not remarkably enlarged. Microscopic examinations showed considerable evidence of hemolysis, as indicated by the presence of blood pigment in the liver and spleen. The bone marrow revealed hyperplasia of the red blood-cell-producing elements.

Case 6—Iso-immunization in the ninth pregnancy. Baby J. C., a patient of Dr. B. J. Wyland, was born by normal delivery at St. Joseph's Hospital, Mishawaka, on Nov. 15, 1945, and was submitted for examination because of numerous elevated bluish areas on the skin surface which appeared on the fifth day of life. There was no jaundice; hemoglobin was 128 per cent (19.2 Gm.). The mother had had eight normal pregnancies. She was found to be Rh negative and had anti-Rh agglutinins in a titre of 1:1. The child was Rh positive. The skin lesions cleared spontaneously, and were believed to be due to congenital fat necrosis.

CONCLUSIONS

1. With present laboratory methods it is possible to diagnose accurately almost every case of congenital hemolytic anemia of the newborn (erythroblastosis fetalis). The great majority of erythroblastotic infants born alive can be saved by giving blood transfusions. However, no effective method is known for saving infants from the lethal effects of certain hepatic injuries sustained as a result of the disease or from brain damage associated with kernicterus or hemorrhagic manifestations.

2. In the treatment of congenital hemolytic anemia immediate transfusion of adequate amounts (10 cc. per lb.) of Type O Rh negative blood should be given by the intravenous route when the blood count drops below the critical point of 3.5 million red blood cells per cmm., or hemoglobin 65 per cent (10 Gm.).

3. Congenital hemolytic anemia cannot be excluded in the child of an Rh positive mother, as subgroups of Rh positive, the A-B factors, and Hr factor may be concerned.

4. In any given case the incidence of congenital hemolytic anemia in future pregnancies cannot be accurately predicted for the following reasons:

(a) The father may be heterozygous, in which case 50 per cent of the children will be normal.

(b) There are great variations in the antigenicity of the Rh positive cells of a fetus, and great variations in the response of an Rh negative mother's body cells to the stimulus to produce anti-Rh antibodies; that is, some persons are not good antibody producers. Therefore iso-immunization of the mother may not occur even though theoretically possible.

5. Every female should have an Rh test, and if Rh negative, the possibility of future iso-immunization by childbirth or blood transfusion must be considered and adequate measures taken.

6. The Rh type of a recipient should be known before a blood transfusion is given, and if Rh negative, only Rh negative blood should be given.

7. If the mother has not had an Rh determination, we suggest, as a hospital routine, that every jaundiced newborn child should have a complete blood count, and the mother an Rh test as a screening method to promote prompt recognition and immediate energetic treatment of congenital hemolytic anemia.

ABSTRACT

SHELL FRAGMENT REMOVED FROM SOLDIER'S HEART

Two doctors in the Army Medical Corps report the successful removal of a shell fragment from the heart of a twenty-three-year-old American soldier, in an article appearing in the current issue of the *Archives of Surgery*, published by the American Medical Association.

The authors, Lieutenant Colonel William B. Schaefer and Captain Victor P. Satinsky, Medical Corps, Army of the United States, say that the soldier was wounded June 24, 1944, near Cherbourg, France, when a mortar fragment "stung him through his back." X-ray films failed to reveal the shell fragment because of the collection of blood in the chest cavity.

The foreign body was located, however, by fluoroscopic examination which revealed that the object moved with the beat of the heart. Surgical exploration showed the fragment had cut through the lung and penetrated the heart. A small incision was made in the left chamber of the heart and the fragment was grasped and removed by clamps. The patient was given transfusions and treated with oxygen, sulfadiazine, and penicillin.

The authors state that "six weeks following operation the patient was permitted out of bed and graduated exercises were begun. Special exercises were instituted early to assist in the re-expansion of the lung [which was collapsed], to prevent deformity and to aid in the development of the thoracic cage. These exercises were carried out regularly four times daily. Four months after the operation, the patient is in excellent condition."

RECONSTRUCTIVE SURGERY FOLLOWING TREATMENT OF OSTEOMYELITIS BY SAUCERIZATION AND EARLY SKIN GRAFTING

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During the recent war treatment of exogenous osteomyelitis by saucerization and early split skin grafting received an extensive trial in several hospitals in the United States. The techniques as reported by several workers[1 2 3] have been successful enough when used by other surgeons that it seems possible they will find application in treating some cases of osteomyelitis secondary to traumatic injuries of civilian life. Whether or not such techniques will be suitable for chronic hematogenous osteomyelitis is a question being investigated at the present time. So far the results are promising, but the number of cases is limited and no conclusions can be drawn.

It should be emphasized that the above-mentioned papers present techniques for treating osteomyelitis. The split skin graft is used as a tissue dressing to give rapid epithelial covering of the saucerized area and not for cosmetic reasons. The curing of the infection is the primary interest at that stage, and the reconstructive needs of the case are temporarily of secondary importance. However, once the osteomyelitis is controlled it is necessary to evaluate the case as to the ability of the bone and soft tissue to withstand the normal stresses of life. No case should be discharged as completed until there is sufficient bone for ordinary function, soft tissue that will not break down under normal trauma, and a good cosmetic result. Each case must be evaluated separately as to the needs for reconstructive surgery; however, there is enough similarity in many cases to allow a few broad generalizations to be made. This paper presents some of the techniques that we found useful in the reconstruction of cases that had previously received split skin grafts for treatment of osteomyelitis.

INDICATIONS FOR REPLACEMENT OF GRAFTS

In our initial paper on the subject it was stated that we felt optimistic about the possibility that split skin grafts would hold up permanently in sites where trauma and motion were not excessive. [Burgess, Ernest, and McClintock, James A.: Osteomyelitis Treatment by Radical Saucerization and Early Skin Grafting—monograph prepared in mimeograped form and distributed to a limited number of orthopedic specialists, March, 1945.] This is still our opinion after following most of the initial one hundred cases to completion and more than three hundred cases for a period of months. Small grafts and those larger grafts that are not over friction areas need no further surgery unless they are cosmetically objectionable. If it is anticipated at the time of the initial surgery that a skin graft will not need replacement, a somewhat thicker graft, 0.018 to 0.022 inch thick, is used since thicker grafts have a more normal appearance.

There is, however, a tendency for even a well-healed split skin graft over bony prominences to break down under friction. It is advisable to replace such grafts with full-thickness skin. Also split skin grafts that overlie the line of incision necessary for subsequent bone grafting, fusion of joints, or repair of nerve or tendon are replaced by full-thickness skin. This is usually done as some type of pedicle transfer before the definitive reconstructive operation, but combined procedures are used in some cases.

Some patients, despite the fact that they have a functionally good skin graft, object to the cosmetic appearance. Especially in cases where a three-dimensional, skin-lined defect exists in the contour of the limb many patients wish further repair. Such grafts are replaced with techniques described below.

TIME INTERVAL

A minimum of sixty days should be allowed to elapse from the time that the initial split skin graft is healed before any major reconstructive surgery is attempted in the same area. This period of observation has several advantages. The patient is encouraged to participate in moderate physical activity. If possible, the patient is ambulatory, often with a brace when a weight-bearing bone is involved. The results in terms of improved muscle tone, better circulation, and good mental attitude of the patient is important in preparing him for reconstructive procedures.

Such moderate activity is also a test of the completeness of the healing of osteomyelitis. Any latent infection will become more active. However, we have been surprised to notice how few cases of osteomyelitis treated by an adequate saucerization and skin grafting procedure show recurrence. In some cases daily provocative massage was applied to the area of previous infection for periods as long as two weeks with little sign of inflammation.

Another advantage to a period of observation is the opportunity it allows to test the durability of skin graft in an area where it is difficult to decide whether replacement with full thickness skin

[1] Kelly, Robert P.; Rosati, Louis M.; and Murray, Robert A.: Traumatic Osteomyelitis—The Use of Skin Grafts. *Ann Surg.*, **122**: (July) 1945.

[2] Knight, Marvin P. and Wood, George O.: Surgical Obliteration of Bone Cavities following Traumatic Osteomyelitis. *J. Bone and Joint Surg.*, **27**: (October) 1945.

[3] McClintock, James A.: Osteomyelitis, Treatment by Radical Saucerization and Early Skin Grafting. *J. Indiana St. Med. Assoc.*, **39**:9-14, (Jan.) 1946.

is necessary. If the patient is in good condition it is possible to outline and undermine a pedicle flap or form a tubed pedicle during this period if such procedures will be necessary for the reconstruction. Patients are placed on a high protein, high vitamin diet during this time, since plastic surgery gives better results if the patient is in good nutrition.

CARE OF SPLIT SKIN GRAFTS

Split skin grafts require little care once the initial healing process is completed. Soap and water cleansing at the same time as other bathing of the patient is sufficient in many cases. In the base of deep clefts there is a tendency for the skin to macerate. Exfoliated epidermis will collect in these areas and lead to some inflammation if not removed. Such a difficulty is obviated if the deep clefts are cleaned two or three times a week with cotton-tipped applicators dipped in 70 per cent alcohol.

It has been found that split skin grafts directly over bone in friction areas develop superficial abrasions or ulcerations in about 10 per cent of the cases even though the graft was previously well healed. Most of these represent small traumas to the grafts that disturb the blood supply locally. In almost every case simple bed rest and elevation of the extremity will cause prompt healing. An occasional graft has developed a hematoma that leads to necrosis of the undermined portion of the skin graft. In this case a block resection of the devitalized area is done, and either a small split graft or multiple pinch grafts are applied. Prompt healing usually ensues.

APPEARANCE OF BONE AND SOFT TISSUE

As reported in a previous paper,[3] the bone underlying the skin graft has an x-ray appearance that is almost normal in texture. Usually neither excessive sclerosis nor osteoporosis can be seen in x-rays taken sixty days or more after the saucerization. The bone fills in slowly in the saucerized area. However, on inspection there is an alteration in the gross appearance of the surface. The bed on which most of the split grafts were placed consisted of coarse cancellus bone with a thin layer of granulation over it. On removal of the skin graft from this bed the surface has a compact, fine-grained appearance resembling cortical bone. There is little bleeding from this surface, but if it is resected superficially with an osteotome the bone underneath is found to be very vascular.

The soft tissue under the split graft also presents a vasular bed which is very satisfactory for subsequent plastic procedures. Dense connective tissue like that which forms with the closed plaster technique of wound healing is limited and consequently contracture is held to a minimum. This limits the binding of muscles and fascia in scarring, and thus tends to preserve joint motion.

TECHNIQUES USED IN REPAIRING SOFT TISSUE DEFECTS

Considerable ingenuity is needed to repair some of the defects, and once the osteomyelitis is cured it seems best to be conservative in the handling of a case. Some patients with large defects that initially represented a marked problem, if allowed sufficient time, underwent changes as inflammation subsided, edema disappeared, and soft tissue filled in that allowed the case to be completed with simple operations.

In general, it is desirable to replace the split skin grafts not only with full-thickness skin, but also with enough subcutaneous tissue to furnish a thick, pliable padding over exposed bony prominences. Such a repair, as well as protecting against possible future breakdown of the skin, often improves the appearance of an extremity, filling up a depression and giving a normal rounded contour. The following reconstructive techniques, presented with some of their limitations, are frequently useful.

EXCISION AND CLOSURE

The simplest soft tissue reconstructive technique is that of excision of the split skin graft and closure of the defect. We have used this technique as a separate procedure and in conjuction with bone grafts and other major orthopedic surgery. It is limited in its usefulness because in most areas of the body it is impossible to obtain sufficient relaxation of surrounding tissues, even with undermining, to close the defect without excessive tension. If there is too much tension on the suture line a wide scar results that is no better protection than the split skin graft.

SLIDING FLAP

In some cases where it is impossible to do a simple excision of a graft and closure it is possible to make a parallel relaxing incision and shift adjacent skin and subcutaneous tissue over the friction area. A similar local technique is the rotating of a flap of nearby tissue. Such a procedure is limited in the amount of tortion that is possible without damage to the circulation of the flap. Both procedures have limited usefulness as they create a defect that must be covered by a split skin graft, thus they must come from areas where friction is unimportant.

TISSUES TRANSFERRED FROM A DISTANCE

At times the defect that is lined with a split graft is so large that it is impossible to use a slide flap technique for coverage. In this situation it is advisable to obtain full-thickness skin and subcutaneous tissue from another area of the body. If extensive bone grafting is to be done in the same area, it is best to have good soft tissue coverage assurred before the bone grafting is attempted. To obtain suitable soft tissue we use a pedicle flap or tubed pedicle. Cross leg flaps from the opposite calf often work well in the lower extremity; whereas abdominal or thoracic flaps are suitable for transfer to the upper extremity. Most frequently we have used the abdomen as a donor site for tubed pedicles, since wide tubes may be removed from this area with relatively little cosmetic or



FIGURE I

X-ray one month after filling the cavity with bone chips.

functional loss. These tubes were usually shifted to the wrist as an intermediate step to facilitate moving to the recipient area. The tubed pedicle has several advantages. Large amounts of tissue can be obtained in this way from distant donor areas. Tubes are easy to care for as there is no open fat surface like that encountered in most techniques with the pedicle flap.

In small deep cavities where bone is not needed for support the derma-fat technique may be used to obliterate the defect. However, marked shrinkage of the fat is to be expected and must be estimated and allowances made to compensate for the tissue loss. In cases where it is possible the transfer of muscle bellies to fill defects is a simpler procedure and carries less risk of failure.

It is important in any pedicle that is to be undermined subsequently for other reconstructive procedures that the transplant be of such a size and so situated that not more than one-half of the tissue will be elevated, preferably less. There is always a tendency for the circulation to such a flap to be curtailed for some months. It is best that no procedure that will undermine a large flap be attempted before ninety days after its transfer. If possible, in subsequent surgery one of the old suture lines should be used rather than making an incision through the previous pedicle. Although pedicle surgery is often time-consuming for both the patient and surgeon, the results obtained are usually superior to those obtainable with extensive one-stage procedures.

COMBINED OPERATION

One of the most useful of the one-stage procedures is an operation that combines a bone graft and a sliding or rotational flap. It is especially useful for defects of the proximal two-thirds of the tibia. These defects are of the general type seen so often in bumper fractures with subsequent osteomyelitis. Such areas following the eradication of the osteomyelitis with the saucerization, split skin graft method, show a defect anteriorly with a loss of bone that is so great that unsupported weight-bearing is dangerous and any unusual strain may cause a re-fracture. The operation outlined below corrects both the soft tissue and bony defects. Due to a limitation on the number of illustrations, the reader is referred to a previous paper[3] where Figure VI, an illustration of the case of F.S., is an example of a defect suitable for this method of repair.

The skin is prepared by any standard method. The draping should leave ample exposure at the recipient site in the tibia, at the donor site along the crest of the ilium, and at some site suitable as a split skin donor area.

An incision is made along the margin of the split skin graft and is followed down by sharp and blunt dissection. A plane of cleavage is found just under the skin graft where the dissection is easiest. There is no difficulty in separating the skin graft from the underlying bone. The skin graft having been completely removed, the bed is packed with warm normal saline packs and the attention is turned to obtaining soft tissue to cover the defect. The adjacent skin is widely undermined on all sides. The plane of separation is just superficial to the deep fascia. At this level relatively little bleeding is encountered. After the tissues have been freed a preliminary effort is made to slide them, like a roof, over the defect in the leg. Thus, one can determine if the skin will close without undue tension. In most of our cases the result was better when a relaxing incision was made parallel to the long axis of the defect. In this way it was possible to reduce tension on the suture line, and the circulation was improved. Having prepared the recipient area, the next step is to obtain a bone graft from the ilium to fill the defect in the tibia. This graft serves a two-fold function since it adds to the strength of the bone at its area of questionable strength and obliterates the cavity, thus allowing a smaller amount of skin to cover the defect.

Although we have never had a cross infection, we feel that one should change gown and gloves before taking the bone graft. To obtain the bone graft an incision about four inches long is made parallel to the crest of the ilium, starting below and posterior to the anterior superior spine. The gluteus medius muscle is reflected downward. It is then easy to obtain relatively large amounts of bone from the ilium with simple bone instruments. After sufficient bone is obtained the wound is closed in layers with interrupted sutures. A pressure dressing is used, for troublesome oozing is sometimes encountered. The iliac bone is cut



FIGURE II

External appearance of case shown in Figure I.

into small pieces, about 1 cm. in the largest dimension, which are kept in a warm saline pack until ready for use.

The surface of the bone in the recipient area is shaved with an osteotome to obtain a fresh surface suitable for nourishing the iliac bone chips. This cavity is then packed tightly with the bone chips. If it is desired, one large piece of iliac bone may be used as a central mass in filling the cavity and smaller chips fitted about it. In either case it is important that the iliac bone be placed carefully so that there will be no large dead spaces between the fragments to collect serum.

Once the bone chips are placed to the surgeon's satisfaction, they are tapped lightly to pack them more firmly in place. An effort is then made to obtain a fascial layer of coverage. Usually the deep fascia, a muscle sheath, or some similar structure can be shifted to cover all or most of the defect. The subcutaneous tissue is closed as a separate layer to keep a depressed scar from forming. The skin is closed with interrupted sutures of silk, cotton, or stainless steel wire. If a relaxing incision has been made, a split skin graft of sufficient size is used to cover the defect created when the flap is slid over.

The dressing should be a firm, resilient, pressure dressing. A single layer of boric acid gauze is used directly over the wound, followed by a layer of fine machinist's waste, wet in normal saline, and then a layer of abdominal pads. An Ace bandage is applied as firmly as the circulation of the extremity will permit. A light plaster cast is applied for immobilization.

Following surgery the extremity is elevated on three pillows for several days. Penicillin is administered as a prophylactic measure, but it will not compensate for faulty packing of the bone chips or insufficient pressure to keep serum from collecting in the wound. At the end of ten days the sutures may be removed from both the donor and the recipient area. Thereafter dry dressings are usually sufficient. The extremity should be protected by a light cast for about six weeks; however, after about four weeks the bivalved cast may be removed daily and active joint motion started in most cases. Follow-up x-rays are used to determine the proper time to begin weight-bearing. Figure I is a print of an x-ray taken one month after such an operation. In it the iliac chips are uniting, but have not as yet lost their identity. Figure II represents the soft tissue appearance of the same leg. One can see a portion of the split skin graft that covers the relaxing incision posteriorly and the scar representing the suture line over the tibia. The contour of the leg is almost normal.

CONCLUSIONS

A method of treating exogenous osteomyelitis by saucerization and early split skin grafting has been successful enough so that it seems possible that it will find increasing use in civilian practice. In many such cases the need for better skin coverage, for bony support, or for cosmetic reasons make it necessary to do reconstructive surgery. Several useful methods of soft tissue and bone repair are hereby outlined.

ABSTRACT

PENICILLIN EFFECTIVE AGAINST ACUTE SKIN DISEASE CAUSED BY CONTACT WITH DISEASED ANIMALS

Penicillin has come to the aid of workers whose occupations bring them in contact with animal hides or other animal products. This antibiotic drug has been found effective in the treatment of a burrowing infectious disease of the skin known as anthrax, according to an article appearing in the August 3 issue of *The Journal of the American Medical Association.*

The authors are Major Harold V. Ellingson, Medical Corps, United States Army; Captain Paul J. Kadull, Captain Henry L. Bookwalter, Medical Corps, Army of the United States, and Lieutenant Calderon Howe, Medical Corps, United States Naval Reserve, Station Hospital, Camp Detrick, Frederick, Maryland.

The anthrax bacillus is transmitted to man through contact with diseased animals or infected animal products. Anthrax is characterized by a gangrenous carbuncle-like lesion surrounded by swelling and an abnormal accumulation of water in the tissues. The disease is always serious.

Reporting on twenty-five cases, the authors say that in several patients the infection occurred at sites of previous wounds. One of these lesions appeared at the site of a cigarette burn on the face, two developed at sites of abrasions on the fingers, and one occurred in a hangnail. Among the remaining twenty patients several believed that they had had ordinary pimples at the sites where anthrax lesions later appeared.

The first evidence of infection is the appearance of a small red spot on the skin accompanied by intense itching. The spot grows within a few hours into a sac containing fluid. This sac may rupture early, leaving a small ulcer, or may enlarge by direct extension or by development of a ring of such sacs. Within two to six days after onset, the sac ruptures and begins to dry, and the swelling recedes. In drying, a tough, black crust is formed which is characteristic of this infection. This can usually be removed easily in ten to fourteen days after onset, but is sometimes firmly embedded and may persist for long periods, finally leaving a punched-out ulcer which slowly fills with new skin tissue.

Treatment was begun as soon as diagnosis was made, the article states. All patients were treated with penicillin in total dosages from approximately 1,000,000 units to over 4,000,000 units. The authors find it significant that in twenty-two of these cases the anthrax bacilli disappeared from the lesions in twenty-four hours or less.

Although the lesions passed through the different stages of the disease after treatment, all patients recovered uneventfully; therefore, the authors believe that "penicillin may have modified the course of these infections and that this therapeutic agent deserves further clinical trial in the treatment of cutaneous anthrax."

ANESTHETIC PROGRESS*

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Anesthesia may be defined as the clinical manifestation resulting from the saturation of the brain, cord, or nerve trunk with an anesthetic agent, and the depth of anesthesia depends upon the degree of saturation. Anesthesia as we know it today is of comparatively recent origin and advances in surgery have been in direct proportion to the advances made in anesthetic technique and development of anesthetic agents.

Surgical procedures heretofore impossible have been made practical and successful by the advent of modern anesthesia.

Throughout the ages footprints in the sands of progress show man's attempt to find surcease from pain and mental anguish. Primitive man resorted to bathing an aching or wounded part in steaming jungle mud or icy brook, the hypnotic influence of weird music and incantation, or the administration of various stupefying brews and herbs. These were but crude forerunners of our present-day armamentarium for the relief of pain. Temples erected to their gods by people of ancient civilization and the influence of the medicine man in savage tribes have created monuments from which the modern world was destined to recover the course and character of early progress.

The road to modern anesthesia has been rough and replete with many detours. Our efforts have been filled with hope and despair, comedy and tragedy, elation and disappointments, success and failure, hate and greed, yet through it all has evolved what we regard as a marked degree of success.

Advancement in the art of anesthesia has been noteworthy. New and more or less complicated apparatus has been and is constantly being devised. The introduction of new anesthetic agents and the greater skill required in their administration is of vital importance and must be diligently developed. The future will determine the value of our contribution. The multiplicity of agents, the wide variance of techniques, and the lack of a universally-approved procedure might well indicate that the ideal goal has not yet been reached and that future investigation and effort will prove our present methods outmoded and obsolete.

The present era of anesthesia is comparatively short. Morphia for the relief of pain was presented in 1806. The effective use of anesthetics in surgical procedures really began in 1842, and during the period between 1842 and 1850 the development and use of ether, nitrous oxide, and chloroform gave us three anesthetic agents which to this day play an important role in our procedures. Ethylene was introduced in 1923; avertin in 1925; cyclopropane in 1928; divinyl ether in 1930; trichlorethylene in 1935; cyprome ether in 1940; refrigeration anesthesia in 1942; and caudal anesthesia in obstetrics in 1942. During this period, since 1924, intravenous anesthesia has shown a remarkable growth, and today those employing intravenous anesthesia, while recognizing its danger when used by a novice, are enthusiastic over its advantages in experienced hands.

No field in medicine is fraught with more hazard than anesthesia. The altered metabolism, the physiological imbalance and the depleted vitality, due to pathological disturbances, render the patient an exceedingly variable factor whose reactions can only be anticipated and not prejudged.

Four factors might be considered as highly important in any surgical procedure requiring anesthesia:

1. The anesthetic agent. Any agent capable of suspending animation in all but the vegetative functions, and indeed all functions, deserves our greatest respect. The agent used must be safe, must be sufficiently potent to secure desired results, and must leave a minimal deleterious effect on recovery and physiological balance. To secure this advantage the agent of choice must be selected by an individual of wide clinical experience. The efficiency of any agent must be determined by clinical experience and adaptability to the various demands of changing conditions, physiological and pathological, encountered in the operating room rather than in the experimental laboratory.

2. The ability of the anesthetist to judge the requirements of the procedure, the potency of the agent, the physiological, psychological, and pathological condition of the patient necessitates a knowledge of other fields of medicine. Upon the anesthetist, more than the agent used, depends the satisfactory consummation of a dangerous procedure. Certain conditions contraindicate certain agents, and one should be capable of exercising the requisite judgment as to what agent, or combination of agents, and dosage will produce the desired result. For this reason the anesthetist is a more important factor than the agent.

3. The third factor is the patient. It might be fortunate if patients conformed to a stock pattern, with functions and reactions constant. Then our work would be simple but uninteresting. The patient is an extremely variable factor. Reactions, physiological and psychological, influenced by pathological conditions are not and cannot remain constant, thereby requiring able judgment as to what adjustments of dosage or alterations of technique are necessary for a satisfactory procedure.

* Presented before the Eleventh Councilor District meeting at Peru, on May 15, 1946.

4. The fourth factor is the surgeon. A satisfactory anesthetic from the patient's standpoint and the surgeon's standpoint is by no means the same. It is a conceded and proved fact that long, deep, surgical anesthesia is detrimental to normal physiological function, and physiological function altered by existing pathological conditions makes the procedure obviously more dangerous. The surgeon who cannot adjust his technique to the conditions consistent with safety for the patient would serve humanity far better by confining his excursions to the morgue.

At present no universal anesthetic or technique has been discovered; no single agent or method is best for all types of operations. The choice of the anesthetic and technique should be governed by the following factors: (1) the psychological and physiological condition of the patient; (2) the type of operation proposed; (3) the familiarity of the anesthetist with the various agents and techniques; and (4) the ability of the surgeon to perform the necessary procedures under conditions insuring safety to the patient.

The various types of anesthesia in present-day use may be classed as follows: General: inhalation anesthetics—ether, chloroform, divinyl ether, ethyl chloride, nitrous oxide, ethylene, and cyclopropane. Rectal—ether barbiturates, avertin, et cetera. Intravenous anesthesia: barbiturates, spinal, caudal, local or block anesthesia, procaine, cocaine, et cetera. Refrigeration anesthesia.

Each of the above-mentioned techniques and agents have their indications and contraindications which are well known to all of us and need no discussion here.

Unquestionably, ether is the most reliable of all agents for relaxation. When other agents fail to secure desired relaxation safely, ether is either added or substituted, and although it has its contraindications they are probably not so numerous as most other agents. You might well ask then, "Why not use ether and exclude the other agents?" A shotgun will kill a hawk or a crow, but would not be necessary in shooting a humming bird.

To give some idea as to what agents and combination of agents are used in what we think is a modern hospital with a trained anesthetic staff, I should like to present the following report of anesthetics administered in the departments of surgery and obstetrics for the year 1945:

In Surgery—

Avertin	15
Avertin-Ether	222
Avertin-Cyclopropane	132
Ethyl-Chloride	85
Ethyl-Chloride-Ether	3,579
Ether	817
Cyclopropane	2,020
Cyclopropane-Ether	695
Pentothal Sodium	1,035
Spinal	1,572
Spinal—Pentothal	29
Nitrous Oxide	20
Chloroform	9
Total generals during 1945	10,230
Total locals during 1945	4,071

In Obstetrics—

Ether	3,160
Ether and Ethyl-Chloride	7
Ether and local	1
Ethyl-Chloride	5
Cyclopropane	55
Cyclopropane and Ether	25
Nitrous Oxide	3
Pentothal Sodium	6
Spinal and Pentothal	1
Spinal	3
Total generals in obsterics in 1945	3,266
Total locals in obstetrics in 1945	1

This report covers a wide variety of cases as to type of operations, age incidence, as well as surgeons with varying degrees of talent who desire to dictate as to the type of agent or technique used, regardless of the pathology present or their own limitations. At least 85 per cent of ethyl-chloride ether anesthesias were used in ear, nose, and throat cases; spinals were 90 per cent of the low type; intravenous anesthesia was in the majority of cases used in operations of short duration, although it was also used in several cases of lengthy duration, such as brain operations, caesarean sections, mastoidectomies, laryngectomies, et cetera, in some cases requiring two to three hours.

It has been our effort in the use of various agents not to confine ourselves to a single agent when conditions warrant mixtures and addition of other agents. As to the merits and demerits of any agent now in vogue, I leave that to your own judgment, but with this admonition that the criterion of dosage should not be based on percentage or liters per hour, but upon the requisite of the patient at that particular time.

It is obviously impossible that perfection should obtain when so many factors are variable. It is our job to so administer the agents we have so that the patient is brought through that state of suspended animation with the least appreciable damage to the physiological function. The fact that the patient regains consciousness and reflexes is not sufficient to absolve ourselves from further concern. Anoxia and other latent complications are still our responsibility and must be met. The effects of metabolism in health and disease are variable; retention, absorption, and elimination are disarrayed and only to the experienced observer are the least changes manifest.

Accident cases offer a great problem and contribute largely to anesthetic complications. It is seldom that the emergency is so dire on the patient's part that proper time cannot be taken for adequate surgical or anesthetic preparation. Pulmonary complications, asphyxia, anoxia, and in many cases shock, could be averted by proper preparation, and factors which contribute to complica-

tions could be eliminated. The day has come when the anesthetist must be regarded as a vital link in the surgical team. Proper teamwork, adequate preparation of the patient, whether it be by narcosis or fluids, and the selection and skillful use of the proper anesthetic agent are necessary for the successful outcome of the procedure.

In the evaluation of an operative risk, taking into consideration the operative procedure contemplated, and the age incidence, the patient may be classed as follows:

Class 1—An individual suffering from no organic disease or with a localized disease causing no systemic disturbance.

Class 2—An individual suffering from disease causing moderate systemic disturbance.

Class 3—A patient suffering from pathological conditions causing severe systemic disturbance.

Class 4—A patient suffering from systemic disorders which are in themselves a threat to life.

Class 5—Moribund patients.

It is necessary that one be familiar with the disturbances in the operating room, a knowledge gained by association and experience and not from a library. One should possess the knowledge and ability to institute necessary measures as occasion demands before being trusted to watch over the fate of life, death, and morbidity. No longer can we content ourselves with that form of anesthesia which simply renders the patient insensible to pain during the surgical procedure. We must maintain the patient's vitality and physiological balance, reducing the effects of shock so that convalescence will be as comfortable as possible.

THE AMBULATORY TREATMENT OF PHLEBITIS*

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"In the last analysis, we see only what we are ready to see, what we have been taught to see. We eliminate and ignore everything that is not a part of our prejudices."—Charcot.

My excellent results in the treatment of phlebitis with the ambulatory pressure treatment prompts me to describe this treatment, which seems to have been very slightly discussed in this country. In my experience I have found that the most satisfactory treatment of all forms of phlebitis of the lower limbs and their combinations, such as phlebitic ulcer and phlebitic eczema, is the ambulatory pressure treatment as originated by Heinrich Fischer[1] in 1910.

The pressure treatment prevents embolism in almost all cases, cures the phlebitis completely, permits the patient to pursue his usual activities, as it is ambulatory, and relieves the pain immediately after application.

It is therefore far superior to the customary treatment of phlebitis with its prolonged rest in bed, which does not prevent embolism and does not cure the phlebitis, but merely reduces it to its chronic or latent stage, prevents the patient from working, a factor which is economically important for most patients, and does not relieve the pain as does the pressure treatment.

Fischer used pressure at first to treat leg ulcers. His aim was to compress the enlarged superficial veins in order to eliminate the congestion in the tissues surrounding the ulcer.

To achieve sufficient compression for this purpose, he used a complicated bandage similar to Unna's paste treatment, which was rather difficult to apply. He stressed the importance of bandaging the whole lower leg from the base of the toes to the knee, including the heel. Leg ulcers treated in this manner healed completely in a comparatively short time. Fischer regarded the leg ulcers as varicose ulcers until he observed that the inflamed superficial veins in the neighborhood of ulcers healed under the pressure bandages, then he concluded that inflammation of the deep veins of the leg would also respond favorably to this treatment.

These observations encouraged him to use the ambulatory pressure treatment also for the treatment of acute deep phlebitis of the leg. By this courageous decision he gave the medical profession a most valuable treatment for this common and dangerous disease, and it is still the best available method to prevent embolism. Fischer[2] reported in 1924 that he had treated more than twenty-four hundred cases of acute phlebitis of the legs without a single case of embolism.

In applying the pressure treatment, I am using a modification of the original Fischer treatment, which was originated by Meyer[3] and is easy to apply while causing a minimum of discomfort to the patient. In this treatment, which is called the "combination pressure bandage," two bandages are used. First, the soft, moist, medicated Contura bandage is applied to the leg, and then on top of it the elastic adhesive Pressoplast bandage. (See Figure I.)

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* Read before Indianapolis (Marion County) Medical Society, in Indianapolis, April 9, 1946.

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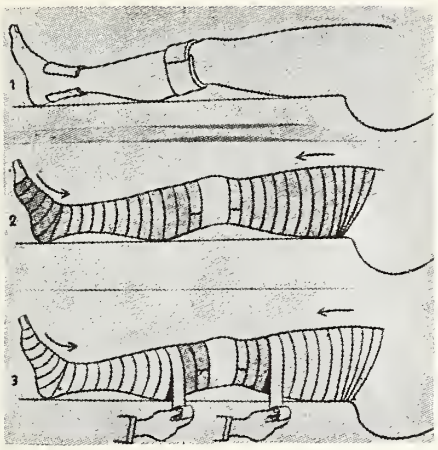


FIGURE I

Application of Contura and Plasto bandages.

1. Protect instep, Achilles tendon, and region directly below knee with gauze spread with vaseline.

2. Apply Contura bandage loosely.

3. Apply Plasto bandage over Contura bandage with strong pressure.

The soothing medication of the Contura bandage protects the skin, prevents contact of the adhesive coating of the Pressoplast bandage with the skin, thereby preventing irritation of the skin and discomfort in changing the bandage; also it eliminates the necessity of shaving the leg. The strong, elastic, adhesive Pressoplast bandage supplies the therapeutic pressure which heals the phlebitis.

The technique of the combination pressure bandage is simple. It can be applied with ease in the office or in the home of the patient. The patient is placed on a flat surface (treatment table in the office, couch, or bed with a hard mattress in the home). Around the ankle and the calf directly below the knee a strip of gauze spread with vaseline is wrapped to protect the ankle bones and to prevent the bandage from cutting into the tissues below the knee. Then the Contura bandage is applied loosely from the base of the toes up to the knee. On top of it the Pressoplast bandage is applied under strong but even pressure in the same manner.

In bandaging the thigh, the bandage starts directly below Poupart's ligament and is wrapped around the thigh in the direction of the knee. In cases of acute phlebitis a few extra circuits of the Pressoplast bandage should be applied under maximum pressure to prevent embolism.

The knee stays free except where there is phlebitis in the knee region, and in cases of acute phlebitis when the whole leg is always wrapped from the base of the toes to Poupart's ligament; first the lower leg, then the knee, and last the thigh. Each part is bandaged separately. The lower leg and thigh are bandaged as described above. The knee is protected in front and back by a layer of gauze spread with vaseline. Then the Contura bandage is applied loosely, and on top of it the Pressoplast bandage is firmly applied. (See Figure II.)

In the treatment of phlebitic ulcers and phlebitic eczemas, the ulcer or eczema is first covered with a piece of gauze spread with a bland ointment, as cod liver oil ointment, then the combination pressure bandage is applied as described above.

The bandage is removed by cutting both bandages at the same time with an ordinary pair of bandage scissors at the outside of the leg from the toes up to the knee or hip, or from the hip or knee down.

The bandage should be changed as soon as it becomes loose, as a rule twice weekly. As the bandage reduces swelling of the leg rapidly, it may be necessary to change the first bandages daily for the first few treatments, depending on the amount of swelling in the limb when the treatment is started.

In order to get the maximum effect of the bandage the patient must avoid standing and must walk a great deal, at least three miles every day, preferably one mile three times daily.

The treatment must be continued until the last trace of the phlebitis has been cleared. Then there will be no recurrences.

The phlebitis is cured when the deep veins are no longer sensitive (by the Meyer[3] pressure points on the deep veins—see Figure II). The muscles must be completely relaxed during the deep palpation of these deep veins.

In treating any form of phlebitis, acute, chronic, or concealed (latent) phlebitis, or in treating phlebitic eczemas or ulcers one must always examine both legs, even though one is apparently not

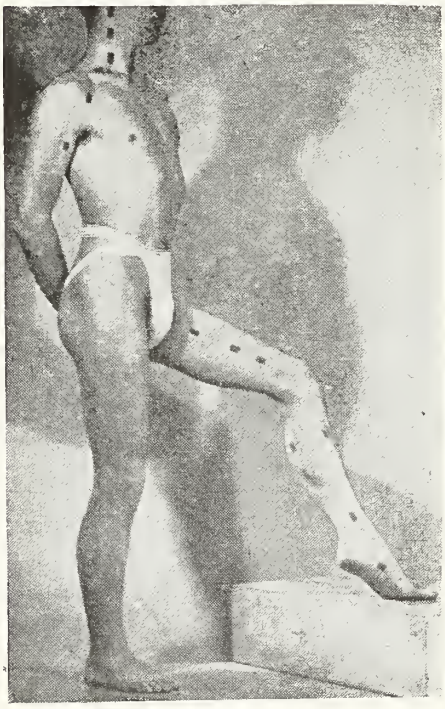


FIGURE II

Meyer's vein pressure points for phlebitis.

affected. In most cases one will find a concealed (latent) phlebitis in the apparently healthy leg (horse-shoe phlebitis). Then both legs must be treated with the combination pressure bandage in order to prevent recurrences or a flare-up of the latent phlebitis. The femoral vein also must be checked in every case, and if found infected, the thigh must be bandaged.

In analyzing the effect of the combination pressure bandage when applied to a leg in which phlebitis is present, we find that:

(1) It compresses the enlarged superficial and deep veins, thereby restoring the function of the valves and also restoring normal conditions of the venous circulation.

(2) In doing so the combination pressure bandage removes the venous congestion, which is always present in phlebitis due to impaired venous return. Venous congestion prevents the healing of the phlebitis, because, by slowing up the circulation and the inflow of a sufficient amount of arterial blood, it cuts down the oxygen supply of the tissues (anoxia) and chokes them with carbon-dioxide and metabolites. Under the condition of venous congestion the tissues lose the resistance to infection and their recuperative power. By removing the congestion the combination pressure bandage not only restores normal circulation, but increases it still more, because the firm Pressoplast bandage directs the whole force of the muscular contractions to the veins which, when compressed by the surrounding muscles under these conditions, empty much quicker and more completely than without the pressure bandage in the direction of the heart, thereby making place for the inflow of arterial blood. For this reason, it is so important that the patient should walk much and regularly, and avoid standing; for in walking the muscles contract maximally, while in standing the activities of the muscles is insufficient to lift the venous blood against the force of gravity to the heart.

(3) The combination pressure bandage, by compressing the walls of the veins, brings them in close contact with the thrombus, gripping it tightly and thereby incarcerating it securely, so that it cannot become detached. In the enlarged vein a thrombus, being as a rule attached to the wall of a vein only with a small part of its surface, floats freely in the blood stream and is therefore always in danger of being torn off by the blood which rushes past and around it. Especially is this the case if the blood pressure rises suddenly due to emotional or physical exertion; then the increased velocity and pressure of the blood stream tear the thrombus from its insecure anchorage and changes it into an embolus. But when the walls of the veins press closely at the thrombus from all sides due to the action of the combination pressure bandage, it is safely incarcerated and kept in position even when the velocity and pressure of the blood stream increases abnormally.

In many cases of phlebitis, especially chronic and latent chronic phlebitis, it is necessary to supplement the ambulatory pressure treatment of phlebitis of the legs by removing every foci of infection in the body in order to prevent reinfection during the treatment and recurrences after completion of the treatment.

Therefore, teeth should be examined by a competent oral surgeon and the tonsils by a competent laryngologist, and the jugular veins, which are the most common and frequent foci, should be carefully examined in every case of phlebitis of the legs. Especial care must be taken to locate tiny root fragments and localized osteomyelitis of the jaw bones which develop not infrequently after extractions, as shown by Fischer.[4] Diseased tonsils should be removed after extraction of infected teeth, because they act as eliminating organs for teeth which are infected. Chronic jugular phlebitis which often develops following tooth and tonsil infections per continuation through the small connecting veins should be removed last by the application of leeches. If treated before tooth and tonsil infections have been cleared up, the jugular veins will become reinfected. Infected and devitalized teeth must be x-rayed and removed as outlined by Murray.[5]

Infected tonsil stumps should be removed, for although they do not produce visible symptoms or subjective symptoms, such as pain when swallowing, they are, nevertheless, foci of infection and more dangerous than unremoved, diseased tonsils, because the covering scar tissue seals in the infection and prevents drainage of the toxins to the outside.

The report of a few cases of ambulatory phlebitis will, I believe, be of interest:

(1) Mrs. M. R., aged forty, housewife, mother of six children, developed a severe pain in her left limb during the last trimester of her sixth gestation, in August of last year. The condition grew gradually worse, and early in September she went to bed because of the pain on being around on her limb. She developed a phlebitis that kept her in bed until December 22, 1945, when I first saw her in consultation with her physician. Her left limb measured thirty-seven and one-half inches around the thigh, whereas her right limb was twenty-nine inches. Using the above treatment, getting her on her feet and insisting that she walk, when the bandage was changed five days later her limb had gone down eleven and one-half inches, and the other limb three inches. She has continued to improve, and the last examination showed the soreness completely gone from the deep veins in both limbs.

(2) Mrs. R., housewife, aged forty-eight, gave a history of almost continuous metrorrhagia that on examination required a hysterectomy. Three weeks after her return from the hospital she developed a pain in her right leg, which we diagnosed as phlebitis following an operation. This was treated with the combination pressure band-

[4] Fischer, Martin H.: *Death and Dentistry*, Thomas, 1941.

[5] Murray, M.: The Relation of Dental Disease to Sinusitus. *The Laryngoscop*, St. Louis, (May) 1943.

age, and on last examination she was completely well.

(3) Mrs. U., housewife, aged fifty-nine—this is the patient that I reported upon before this society a year or more ago, who had an ulcer of her limb, as being well after a fifteen-day treatment, and who has remained so up to the present time.

We have treated many other cases of phlebitis which have responded equally well to the treatment.

SUMMARY

The ambulatory pressure treatment with a combination pressure bandage is the most effective and simplest method of treating all forms of phlebitis of the leg, because it effects a complete cure without the danger of recurrences; it always prevents embolism; it permits the patient to continue his work during treatment; and it relieves pain immediately upon application. In order to prevent reinfection of the veins of the leg during treatment and recurrences after completion of the treatment, all foci of infection in the body must be eradicated, the most frequent of which are infected teeth, diseased tonsils, and chronically-infected jugular veins.

THIOUREA AND ITS DERIVATIVE THIOURACIL AS A GOITROGEN

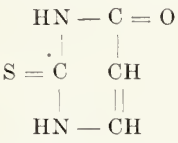
IVAN E. BRENNER, M.D.

WINCHESTER

Many years ago men interested in the thyroid gland noticed that excessive use of cabbage, which belongs to the Brassica family, produced an enlargement of the thyroid gland. In the last few years we have noticed, as have other students interested in the thyroid function, a thyroid hyperplasia after long continued use of thiocyanate.

It is an interesting fact that when iodine is administered with the goitrogens; thiocyanate, or members of the analine series, there is no change in the thyroid gland.[1] However, this does not hold true for thiouracil, but if thyroxine or dessicated thyroid extract is given with thiouracil there will be no change in the gland.

Thiouracil is a sulphocarbamide with the oxygen of urea replaced by sulfur. Its structural formula is:



It is excreted in the urine practically unchanged.

The therapeutic use of thiouracil in thyrotoxicosis came about because of the experimental work of MacKenzie[2] and McCullum, Richter and Clisby, and later Astwood and Williams and Bissell. Their work showed definite enlargement of the thyroid gland in rats. They also proved that thiouracil would lower the metabolic rate.

We began the use of thiouracil in selected cases of thyrotoxicosis two years ago, and have sent in our final reports. I have read the findings of the other men doing this work and found that the final results are similar.

Most of our cases were treated while continuing their usual active life, and we noticed very little disturbance or inconvenience. In several of the cases we had nausea and vomiting, vertigo, eczema, and leukopenia.

We found that if we discontinued the drug for a few days and then gradually returned to the prescribed dosage that for the most part we had no recurrence of toxic symptoms.

The dosage of thiouracil is 0.2 Gm. three times a day for the first two to three weeks, then 0.2 Gm. twice daily until the basal metabolic rate has remained normal for six weeks, and then a maintenance dose of 0.1 Gm. daily. This dosage we found effective in most of the cases. However, in two especially bad thyrotoxicosis cases we were compelled to use about 2.0 Gm. daily.

There has been considerable study of the histopathology of the thyroid gland where thiouracil has been used, but up to date its mechanism is only partially understood. First of all it must be considered a thyroid depressant and that it produces its clinical reaction by blocking the production of thyroxine by the thyroid gland.[3,4] For some unknown reason the gland fails to take up the required amount of iodine from the blood stream, and at the same time loses its own iodine content. Second, experimentally, in the animal where the

[1] Astwood, E. B.: Chemotherapy in Hyperthyroidism. *Surgery*, **16**:679-687 (Nov.) 1944.

[2] MacKenzie, C. G., and MacKenzie, J. B.: Effect of Sulphonamides and Thioureas on the Thyroid Gland and Basal Metabolism. *Endocrinology*, **32**:185, (Feb.) 1943.

[3] Higgins, George M.: A Consideration of the Physiologic Action of Thiouracil and Other Goitrogens. *Proc. Mayo Clinic*, page 310, 1944.

[4] Astwood, E. B., and Bissell, A.: Effect of Thiouracil on the Iodine Content of the Thyroid Gland, *Endocrinology* **34**:282, (April) 1944.

anterior pituitary lobe had been sectioned, thiouracil had no effect upon the thyroid gland either histopathologically or clinically. Third, it produces a reduction in the blood iodine, and the blood iodine level gradually returns to normal as the basal metabolic rate falls. After prolonged use of thiouracil the blood iodine content returns to normal.

While these various changes are taking place outside the gland, it is of interest to note that the cells of the thyroid continue to show hyperplasia as during the active clinical hyperthyroidism.[3] It may be assumed then that the increased vascular state of the gland comes about because of the continued hyperplastic thyroid. It is generally accepted that the hyperplasia of the thyroid gland, while under thiouracil medication, is not changed except in some instances where it is definitely increased.

The cases under our care where the gland was fairly firm at the beginning of treatment did not change to any appreciable extent, and showed very little hyperplasia. In other words, the effect of thiouracil on the thyroid gland depends to a great extent on the condition of the gland at the beginning of treatment.

The physiologic action of the drug is summarized by Astwood:[5] "Shortly after the drug is administered the organism becomes unable to synthesize thyroid hormone at a normal rate and the quantity of circulating hormone tends to fall. In response to this deficit an excess of thyrotropin is produced by the pituitary, which stimulates the thyroid to hyperplasia and to the release of the normal thyroid hormone stores therein. Within forty-eight hours of the first administration of the drug these compensatory changes are histologically visible, and for a number of days the mechanism is adequate to maintain the metabolic rate at a normal level. Eventually, however, the store of normal thyroid hormone is exhausted, as evidenced by a complete loss of demonstrable colloid at the end of seven to ten days, and as new hormone can be made only at a reduced rate the metabolic rate falls even though hyperplasia is still advancing."

Effect of Thiouracil on Toxic Thyroid Symptoms

The symptoms of nervousness, nausea, dry skin and tremor, in fact all subjective symptoms, were the first to respond under treatment. The regression of symptoms ran parallel with the fall of the metabolic rate. The basal metabolic rate returned to normal in most of the cases in from six weeks to four months.

The tachycardia disappearance was somewhat slower, but in all the cases after balancing the dose the heart rate returned to normal. In most of the cases there was an increase in weight of ten to thirty pounds at the expiration of the treatment. Length of treatment varied, the shortest being of only six weeks' duration, and the longest six months' duration. The treatment seems to have no effect upon exophthalmos.

[5] Astwood, E. B.: Treatment of Hyperthyroidism with Thiourea and Thiouracil. *J.A.M.A.* **122**:78, (May 8) 1943.

In cases where cardiac decompensation was present we noticed a gradual return to normal, and in most of the cases the auricular fibrillations disappeared, as per electrocardiograms. It is still too early to determine whether we will have recurrences following the use of thiouracil. We had two recurrences, but perhaps stopped the treatment too soon.

Others interested in this work have reported recurrences, in some cases after fifteen months of treatment, but with early return to normal after returning to the use of thiouracil.[6,7] Certainly we have no other drug at this time that gives a more complete remission, but we must also keep in mind that we are dealing with a very toxic drug.

Toxic Reactions due to Thiouracil

We will mention only a few of the toxic disturbances, the ones most often encountered. The alteration in the white blood cells seems to be its most toxic reaction. Leukopenia or simple reduction in the number of white cells is seen in most of the cases while on thiouracil therapy.

Granulocytopenia and true agranulocytopenia are the more severe types noted, and if not apprehended early may lead to a mortality even under penicillin treatment.[8] There have been several deaths reported in agranulocytopenia following the use of thiouracil. Since these blood changes may occur at any time during treatment, and usually come quite suddenly, it is obvious that a very careful blood count check must be kept in all cases.

We noticed some fever in a few of our cases, but we found that by changing to thiobarbital 0.2 Gm., was usually effective. The maculopapular rash quickly disappeared after discontinuing the drug for a few days and then returning gradually to the prescribed dosage.

In severe toxic thyroids where it is impossible to control the symptoms with Lugol's solution, thiouracil is the drug of choice in preparing for thyroidectomy. However, the use of the drug should be discontinued as soon as safe, and Lugol's solution should be given two to four weeks to bring about involution of the gland so as to get away from the annoying symptoms of hemorrhage and friability one encounters if operating while the patient is still taking thiouracil.

NOTE: The thiouracil thyroid gland is no different from the hyperplastic thyroid that has had no treatment. Thiouracil, in my opinion, is a fairly safe therapeutic measure, but must be used with caution and only when it is possible to keep a very close check on the clinical and blood picture at all times.

[6] Moore, F. D.; Sweeney, D. N.; Cope, Oliver; Rawson, R. W.; and Means, J. H.: The Use of Thiouracil in the Preparation of Patients with Hyperthyroidism for Thyroidectomy. *Ann. Surg.* Vol. **120**, No. 2, (Aug.) 1944.

[7] Williams, R. H., and Clute, H. M.: Thiouracil in the Treatment of Thyrotoxicosis. *New England J. Med.*, **230**:657-667, (June 1) 1944.

[8] Trasoff, A.; Wohl, M.; and Mintz, S.: Fatal Agranulocytosis with Autopsy following the Use of Thiouracil in a Case of Thyrotoxicosis. *Am. J. M. Sc.*, **211**:62-66, (Jan.) 1946.

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SEPTEMBER, 1946

Editorials

YELLOW FEVER HERO DIES

When the press recorded the recent death of John R. Kissinger, formerly of Huntington, few readers immediately recalled the very important role this man played in one of the great dramas of American Medicine, yet some forty-six years ago his name, along with other volunteers from the United States Army, was on the tongue of hundreds of thousands of American citizens and was well known to practically every member of our medical profession. For it was he, with some twenty-two others, who volunteered to serve as human guinea pigs in the successful attempt to eradicate yellow fever.

During the Spanish-American War, in 1898, the invasion of the island of Cuba was attended with a serious loss of our troops, due to yellow fever, and at the conclusion of the war a veritable epidemic of this pestilence broke out all over the island. Army officials were, of course, much concerned about it and set out to do something toward controlling the epidemic. A "Yellow Fever Commission" was organized and sent to Cuba; among its members was a rather frail, young physician, Major Walter Reed. The story of these investigations is well worth reading, and the biographies of William Crawford Gorgas and Walter Reed should be "musts" in the reading program of every physician.

The investigation was most thoroughly carried out; seemingly nothing was overlooked that might lead to some clue as to the real method of transmission of this disease. Volunteers were placed in mosquito-proof tents, along with victims of the active disease, but they did not become infected. Some went so far as to swallow discharges from yellow fever patients, but they, too, escaped.

Finally, Walter Reed decided that the lowly mosquito might have something to do with the disease and set about to make some experiments along this line. He called for volunteers who were to subject themselves to mosquito bites, and in due time most of them developed the fever. Some of them died; a few recovered, and among these was John Kissinger, a Hoosier. Walter Reed personally took charge of the treatment of this man, and after a long siege he recovered sufficiently to be sent home.

When Kissinger learned of the proposed experiments, he and a "buddy," John J. Moran, both Army privates, went to the tent of the three remaining members of the commission and announced their willingness to take part in the experiment. When they were advised that a two-hundred-fifty-dollar bonus would be given all such volunteers, Kissinger is quoted as saying, "The one condition upon which we volunteer is that we receive no compensation whatever. We wish to do this in the interest of science and humanity. Two lives are nothing compared to the thousands of soldiers stationed here." As we have stated, Kissinger came up with a violent case of "Yellow Jack," the name given the disease by the soldiers, while Moran had a light attack.

With the Reed theory well proved, General Gorgas, as chief sanitary engineer, took over, and in due time he had the situation well under control. So thorough was his campaign that yellow fever, save in isolated instances, was eliminated in Cuba, and later in the entire world. In 1900, the year the commission began operations, there were 1,400 cases of yellow fever reported in Cuba; in 1901, just a year later, the number of reported cases was 37. So it may be said that it took about a year to control the spread of this dread disease.

It might be well to remember that we have had yellow fever epidemics in the United States, several of our seaports, notably New Orleans, having been the scene of the infection; today there is no yellow fever in this country.

Some five years after he had returned to his Indiana home Kissinger suffered a relapse, and for some twelve years was more or less an invalid. He lived on the one hundred dollars per month pension that had finally been awarded him—originally this stipend was set at thirty dollars per month. The American Association of Medical

Progress then came to the rescue and presented Mr. and Mrs. Kissinger with a home, in Huntington. Some three years ago the couple went to the Indiana Soldiers' Home, at Lafayette, later removing to Florida.

Thus closes another of the interesting chapters in medical history, and Indiana played a very important role therein, since one of her sons volunteered—offered his very life—in the pursuit of knowledge as to what causes yellow fever, and how to prevent it. In our book, John R. Kissinger is given a page alongside that accorded to Major Walter Reed. Peace to his memory!

THE HOSPITAL SITUATION

Never in the history of medicine has the hospital problem been so acute as it is at the present time. There is a general demand for more and better hospitals, such as we never before have seen. But there are many problems that must be met before a program can be formulated that will be of much success. Not only do we need more hospital beds; *we need more hospital help!*

At a recent meeting we attended the matter of hospitals was being discussed. One speaker made the statement that a hospital in his home city had a half million dollars on hand, for an addition to the hospital, but that "priorities" was holding them up. "However," he added, "even though the building is constructed, what can we do about increased personnel?"

Another speaker—these were all from Indiana—stated that the Sister in charge of the hospital in his town was seriously considering the closing of the institution, due to the fact that sufficient help cannot be had to conduct the hospital efficiently. She had remarked, "I would rather close the hospital than try to operate it with insufficient help; right now we are unable to give our patients the full amount of hospital care they need."

In another section of the state several beds in a local hospital were at least temporarily closed off, an entire wing being closed, all because sufficient help could not be secured.

By "help" we mean every department of the hospital, from the janitors and caretakers on up through the long list of employees needed to carry on a modern hospital. Laboratory technicians, once almost a "drug on the market," are scarce; in many instances they cannot be obtained.

But it is the shortage of nurses that presents the greatest problem. Just what has become of all the nurses we had before the war is a question that has not been satisfactorily answered. Of course, thousands of them went off to war—where they should have gone, but most of them have returned; some went into private duty, some into industrial plants, many into the veterans' hospitals; and the others, we just do not know where.

We have talked with several nurses about this situation, and they are agreed that the matter is becoming serious, but they did not know the answer. Most of them are convinced that there should be more entries into the nurses' training schools, yet a survey indicates that practically all such schools are filled to capacity. Further, it is certain that with the opening of more and more veterans' hospitals the shortage of nurses will probably increase.

For some reason, Mr. and Mrs. John Q. Public has decided that this is a problem for physicians to solve. As they put it, "The doctors are the ones who need more nurses; *ergo*, they should see that they are available." We, of course, disagree with this in the main, although there are many instances in which the medical profession can be of material assistance. For example, among the families whom the physicians treat are large numbers of young girls, just out of high school, many of them looking for "something to do." The family physician, in particular, can do much to persuade these young women to enter training. There still is "glamour" to the profession of nursing; most high school graduates like the appearance of the nurses' uniforms—particularly are they intrigued by their caps.

We all have noted the pride with which the novitiate dons her first cap, later the stripes. In the past few years we have persuaded quite a number of young women to take up nursing as a profession, and while it is true that some have dropped out before completing the course, and others have married soon after graduation, there still are many who have gone on to private hospital duty.

The profession owes something to the solution of the problem, and we urge our members to cast about in their home community, look for "likely" prospects, and get them into a nurses' training school.

"OPTICAL" INDICTMENTS

For many years we have been aware of a decidedly unprofessional practice existing in optical circles, that of accepting rebates for commission on glasses sold to their patients by some of the large optical firms of the country; of course, there are also some small outfits that participate in the nefarious practice. During the past years we have published editorial comment on this, as have other medical magazines. As long ago as 1924 the Section on Ophthalmology of the American Medical Association adopted a resolution, "that the acceptance of commissions or considerations, either directly or indirectly, from opticians and optical houses in the sale of glasses is absolutely contrary to all our standards of medical ethics and is just as reprehensible as the splitting of fees." This resolution did not come before the House; hence, was but the report of a single section.

In 1942 the matter officially came before the House, when a similar resolution was handed in for consideration. The reference committee made some changes in the wording and the House voted "stern disapproval" of any member of the American Medical Association who engaged in such practices. However, "stern disapproval seemed to throw no fear into the hearts of the guilty, for the practice has flourished, there being more ophthalmologists participating in the program than ever before.

The Journal of the American Medical Association of August 3, 1946, editorially comments on the matter and publishes bona fide instances of how these gyp artists work. To begin with, the patient pays the refraction fee to the ophthalmologist making the examination. He is given a prescription and told to go to a certain dispensing optician to select his glasses. One patient paid $25.00 for lenses, the company retaining $10.80 and "rebating" the tidy little amount of $14.20 to the physician. A Chicago patient paid an optician $14.00 for lenses, the physician's commission amounting to $11.50.

These "rebates" mount up rapidly it seems. Attorney General Tom Clark, in a statement to the press, indicated that one group practice outfit collected $42,000 in one year from their optical company; one individual physician got $40,000 from his pet company; while other rebates ranged down to $15,000. So it is evident that there is "soft money" and plenty of it in such a racket.

As a starter in getting rid of such nefarious practice, charges have been filed for violation of the Sherman Act against three of the larger optical manufacturing companies, The American Optical Company, the Riggs Optical Company, and Bausch and Lomb. The Attorney General reported that "The department is informed that the rebating practice is industry-wide, and it presently is expediting its investigation of all wholesalers in the optical field. If investigation shows other similar practices, additional suits will be filed as quickly as possible."

Not only the wholesalers are concerned in the suit about to be filed, but a hundred or more ophthalmologists are named by the Attorney General in his press interview, with indications that this list will be materially increased as time goes on. We would like to hear the "alibis" of some of these medical grafters who have been receiving such an enormous "dividend." We have never believed in the practice, and on occasion have expressed disapproval to some who we knew were engaging therein.

We have been prescribing glasses for more than forty years, and in that time have had many invitations to "join in," always refusing the invitation. The practice is indecent; it is unethical; it is nothing more than a racket; and we are pleased that the Attorney General is determined to do something about it. We have a lot of faith in that Texan, Tom Clark; we feel that when he announces, publicly, that he is "going after somebody," the said somebody is pretty sure to have been a bad actor and needs correcting. We believe that this is just what will happen when the whole affair is laid bare.

THE NARCOTIC SCANDAL

We had just finished our comment on an evil affecting the optical profession and involving a number of ophthalmologists when the news story broke concerning the narcotic situation in our capital city. We have for years been interested in this matter, for over a long period as a member of the State Medical Board we were frequently faced by the narcotic problem, and in a number of instances the board felt it advisable to revoke licenses to practice the healing art in the State of Indiana.

The present scandal is similar to the old pattern, but with some new additions to the methods used by the operators. According to news stories, at least three local physicians were "advised" by a narcotic agent to issue prescriptions for large amounts of morphine. It is alleged that the quantity prescribed was large enough to take care of the wants of the addict, and leave him an additional supply for sale to other addicts. One addict was supplied by two physicians, getting a prescription from each of them every few days, thus enabling him to do a thriving business. Just as we have finally convinced the greater part of the public that addicts are not made by physicians, instances such as this arise.

According to current reports five addicts have been adjudged guilty in the local courts, each receiving stiff fines, plus a jail sentence. The narcotic agent, it is reported, has resigned his position. Just why these cases are worked up by local police and tried in local courts is something we do not understand. For many years the enforcement of the Harrison Law was in government hands, but it seems that in recent years local agencies frequently have taken over. We recall an instance not long ago in another part of Indiana where the local medical society assisted in working up an open-and-shut violation of the narcotic law. The offender was arrested, gave bond, and never came to trial. In due time the case was dismissed, due to "indifference" on the part of prosecuting officials.

Back in the old days, Keene and Baxter, the two agents then assigned to Indiana, would have been on the job and there would have been a prosecution of the federal variety. Times seem to have changed in this regard!

Regardless of the fact that a narcotic agent might have "suggested" that a certain chap be given an official prescription for a narcotic—in a few instances it is alleged this was done via an official letter, the fact remains that the physician

knows this would be irregular and that he should have no part in any such transaction.

The whole thing appears to be a reeking mess, and should have the attention of federal authorities. If a physician is guilty of any irregularity, he should be punished, even to the point of a prison sentence, as formerly was done. These sentences did much to slow up the activities of a small group of physicians who illegally issued such prescriptions.

In the present case one doctor is said to have admitted that he got two dollars each for some of these prescriptions, and another large "batch" netted him the tidy sum of one dollar each. Talk about selling out for a mess of pottage—these chaps outdid Esau in that regard.

We of the medical profession have a decided interest in all violations of the Harrison Narcotic Act; we, as a class, believe in the strict enforcement of the law. We are fully aware that each time such a scandal arises it places a mark against the medical profession. Let's have some old-fashioned law enforcement—let Uncle Sam take over in all such cases. If his own house needs cleaning, let him attend to that duty, along with a definite prosecution of all offenders, be it the laity or the medical profession.

Editorial Notes

The citizens of Rockville and Parke County, desiring to honor the memory of the late Dr. T. J. Collings, who for many years served the residents of that area, are collecting a fund to create a memorial to the much-beloved physician. It is planned to turn the fund over to the Union Hospital, of Terre Haute, where Dr. Collings sent most of his patients who needed hospital care, to be used in the purchasing of equipment or in any other manner decided by the hospital authorities.

One of the farm magazines recently took a private poll among its readers relative to the Wagner-Murray-Dingell Bill proposals for a nation-wide, federal-operated health setup. It was learned from this poll that only one in one hundred of those polled were in favor of such a program, and that but five per cent favored voluntary health insurance. This comes as a bit of surprise, since the "Washington Boosters" long have proclaimed that the farmer was heartily in accord with their plans. The modern farmer, by the way, knows what it is all about. He gets the daily paper every morning; gets the news bulletins via his radio; eats his noon meal while listening to the stock and grain market reports, and, withal, is very much up-to-the-minute, and is thinking for himself.

During July there were fourteen new cases of typhoid fever reported in Vanderburgh County. The water and milk supplies were thoroughly checked by the full-time county health officer and found not to be offending agents, the health officer declaring that it was his opinion that a human carrier, or carriers, is the source of the disease.

Two of our smaller county medical societies have elected to merge with neighboring ones—Brown County merges with the Bartholomew County group, and Owen County has voted to associate with the Monroe County group. We believe that such mergers are wise, for when there are but a few doctors in a county it is quite a task to carry on as a county medical society should operate. In these days of automobile transportation the driving of twenty to fifty miles to attend a medical meeting is no particular chore. It is probable that ere long there will be one or two more such mergers.

Members of the Porter County Medical Society, with the assistance of two county health nurses, have completed the pre-school "round-up" in that community. One hundred ninety-seven youngsters were vaccinated against smallpox, while one hundred seventy-eight were immunized against diphtheria. The entire county was covered, and the whole program is reported to have been a complete success.

Long have we preached this very thing, the immunization of all children against these communicable diseases. Again we repeat, "It is not necessary to have either diphtheria or smallpox in any community."

Just now it would appear that the proponents of socialized medicine in the United States are meeting with some setbacks, but we should not be too sanguine about this. It seems certain that new bills will be placed in the Congressional hopper, once Congress reconvenes. While it may be that these new proposals will not be as extreme as some we have met up with in the past two or three years, yet they will carry provisions that will not appeal to organized medicine. It, therefore, behooves us to keep our fighting equipment in the best of order and to store up plenty of ammunition for the future. The "gang" now holding well-paying, government-agency jobs like the work, such as it is, and like the pay. They also like the bit of limelight which is theirs occasionally. The big brass hats—meaning heads of departments— are at work on new measures, looking toward "the preservation of the health of the nation," as they call it, when as a matter of fact not one of these folk have a medical degree, know absolutely nothing about such matters, yet are trying their utmost to tell us what we should do to be saved!

Dr. J. T. Kime located in Petersburg immediately upon his graduation from medical school some fifty-seven years ago, and still continues to carry on as usual. He is said to enjoy excellent health and to be able to care for his duties in the same manner as in the years gone by. What a book such a man could write; for instance, on "human nature."

Grade "A" milk continues to interest health authorities, as well as the milk-consuming public. Dr. Harold D. Caylor, of Bluffton, head of the local medical society, recently gave an interview to a local paper reporter in which he declared that the people of that community were paying for Grade "A" milk, but not getting it. He remarked that one local dairy for some time sold this high grade milk, but had since discontinued the sale, and that at present no local dairy has the right to use the term "Grade A."

Well, it costs money to make regular dairy inspections, but at the same time it also costs money to treat folk who become ill from unsanitary milk. The answer is, "a full-time county health officer."

Senator Wagner, the chap who wants Uncle Sam to take over the "doctor business," has gotten himself into a pretty little jam with a group of his senatorial colleagues. Presumably concerned about the fact that his pet bill was lost in the shuffle he wanted to keep the thing alive, so he presented a subcommittee report to that body. Immediately a group of senators, some of whom are members of the committee to which the WMD bill had been referred and who had been attending the hearings thereon, recognized that the Gentleman from New York was grossly in error. There had been no such report agreed to by the subcommittee; in fact, it had made no final report of any sort, but friend Wagner dug up an old report, made along in March, and with some changes presented it as an up-to-date compilation. Needless to say he did not get very far with his little scheme; about the only result was that in the future his utterances will be carefully watched. Wagner is obsessed with the notion that he holds the health of the nation in his hands and that he is the real Messiah in that regard; hence, it seems that he will go to almost any length to further his aims.

Attendants upon the annual A.M.A. meeting at San Francisco, in early July, report a large attendance and a most enthusiastic meeting. However, transportation problems seem not to have been fully solved as there was considerable comment on the delayed trains and the facilities thereon. We believe that our railroads are doing the best job they can with the equipment at hand, and it will probably be a long time before we are back on a full pre-war basis.

Dr. Donald Covalt, formerly of Muncie, later with the Army Medical Corps, and now associated with the Veterans' Administration, was in charge of one of the most interesting demonstrations at the recent A.M.A. meeting, in San Francisco. He brought seven paraplegic patients from a nearby Veterans' Administration hospital, at Birmingham, California, in order to show the rehabilitation methods now in use in such cases. The main objective, according to Dr. Covalt, is to get these patients "on their feet," get them started walking. He stated that at least fifty per cent of such casualties can become self-supporting.

Have you made your reservation for the Indianapolis session, October 29-31? If not, it will be well to get busy, thus assuring yourself of accommodations upon your arrival. From all indications this will be the banner meeting in our history. At the recent Council session the preliminary plans were aired, and the general opinion was that never before had such elaborate plans been made for your entertainment and enlightenment. The meeting, along with the exhibits, will be housed in the Murat Temple, which also will be the site of the annual "smoker" and the annual dinner. Ray Smith, our new executive secretary, is working on many of the details, including the commercial exhibit which promises to be the largest in our history. Many new firms who never before have shown much interest in an exhibit at our meetings are now *demanding* space, and Ray is having a tough job trying to make room for them. Yes, it will be a big party—better plan to be there when the opening gun is fired.

FOR PARTICIPATION IN ACTIVITIES PLANNED FOR THE ANNUAL SESSION OF THE INDIANA STATE MEDICAL ASSOCIATION, OCTOBER 29, 30, and 31, 1946, PLEASE FILL IN AND MAIL THE FOLLOWING APPLICATION FORMS IMMEDIATELY:

Instructional Courses ..... Page 458.
Trap and Skeet Shoot ..... Page 460.
Woman's Auxiliary ..... Page 461.

It is necessary that these reservations be made immediately!

President's Page

One year ago the greatest of all wars came to an end; that is, the actual fighting ceased, and the young men who took part in the combat heaved a sigh of relief, proud of the fact that they had a great part in upholding the democratic way of life, and that soon they could return to their homes and families and again enjoy the freedom for which they fought so valiantly. From what we see, hear, and read, I fear that they are disappointed. They are coming back into a chaotic swirl of aggravating events, too numerous to enumerate, but it is sufficient to say that since they went off to war individual as well as mass psychology has deviated from the old way of thinking.

We hope that this new way of life, in the final outcome, will be for the betterment of mankind. During this one year attempts have been made by the diplomats of different nations of the world to perfect a peace so binding that wars will be a thing of the past, but so far very little has been accomplished. In fact, if we may believe our sources of news, the men sitting in on these deliberations are getting further and further apart, mainly through the greediness and jealousies of men and nations, for fear that someone else will get the best deal. We can charge these failures to the lack of understanding of the different ideologies of nations, the lack of a common language, and the historical background of each country. To the average citizen all this diplomatic bickering is very disconcerting, but we must not lose faith. We must stay together, fight together, and, if need be, die together for the things that the American people hold dearest to their hearts—Freedom, and all that the word implies.

If great decisions are to be made, the American public can not be kept in the dark. Information must be disseminated to the people through the medium of the press, radio, and all other available means. If this information is given to them truthfully, I have no doubt that the actions these representatives will take will be for the good of all mankind.

We know and accept the fact that there are subversive forces at work in this country, and there always have been. We are but a few years removed from the practice of witchcraft, in which many persons lost their lives, sometimes through false accusation; others through guilt. A number of other subversive acts could be enumerated, but it is sufficient to say that civilization has developed slowly, feeling its way, making mistakes, sometimes with very high premiums as the cost, but always rectifying the mistakes. The nation has always improved, and everyone reaps the benefits. To my way of thinking, the goal of perfection will never be reached, because, as I see it, there is no end to the game. There is only one team playing, and that is the whole world, and when we have played hard to perfect the way of living of all peoples, and the goal is almost reached, a whole new panorama of beautiful things is revealed. Then we set out on a new play in an effort to obtain the better things that this new goal offers. This type of living should go on forever, holding before us—and we hope future generations—the ideal of a more abundant way of life.

This has been the year of reconversion of American Medicine. Many difficult problems have been solved and many more remain to be solved. Within the next sixty days our state convention will be held. We hope to make it the best ever. This can be accomplished only if everyone will do his or her part to the fullest capacity. Indiana Medicine bears the reputation of leading the way when it comes to constructive, workable plans, no matter what the problem may be. This is accomplished by cooperative efforts of the members working through the different committees of the state association.

J. E. Farrell

POLITICAL MEDICINE AS VIEWED BY ONE OF CONNECTICUT'S PSYCHIATRISTS

[In the current nation-wide debate on the question of political or socialized medicine versus free enterprise in American Medicine, the field of psychiatry might be held up as an example of the results obtained through political handling of medical care, according to Dr. C. Charles Burlingame, president and psychiatrist-in-chief of the Institute of Living, Hartford, Connecticut, one of the oldest psychiatric institutions in the country, in his annual report to the Board of Directors of that institution.]

I am forcefully impressed with the fact that never before in my fifteen years at the Institute of Living, nor in my thirty-seven years in psychiatry, have there been more significant developments at our own Institute of Living, nor in the field of psychiatry as a whole, than during the past year. Psychiatry, which is specifically concerned with man's adjustment to his fellow beings, has an increasingly obvious relationship with education and sociology, which are also concerned with equipping man to survive in the world in which he lives.

In these days of new theories, new doctrines, and new orders, trends in psychiatry and other fields affecting man are significant because they may very well be indicative of things to come. Wisely, we might pause in the rush of the day's work to contemplate the multiple aspects of everyday living.

ROBOT NATION

We have heard a great deal about the self-determination of the individual and his divine right of self-expression. We have even preened our feathers a bit while asserting that every man, woman, and child has a right to be, and indeed should be, an individualist. However, at the same time are there the over-all influences in America toward shaping us into a "robot nation?"

All of us listen to the same radio programs, and only too often our thinking is done for us a la programmer, news commentator, and so forth. On a national scale, we are fed through the Associated Press and the United Press; on a national scale, there are picture services in the newspapers, and there are national magazines, some with twenty-five million readers each. We have our "canned" music. Tens of thousands of the same victrola records are played in hundreds of thousands of homes, each one hundreds of times, and all selected for us according to the opinion of some speculative individuals who decide which will be the most popular, if not the best.

Books are selected for us by The Book of the Month Club, The Literary Guild, and so forth. Not only that, but in many of the leading newspapers we are presented with a weekly record of the best sellers, the accepted criterion for our "must" reading.

Then, do our universities follow too much of a stereotyped pattern, offering much the same college education with similar opportunities, their candidates more or less uniformly processed to emerge more or less uniformly trained?

What America needs, and I say it with temerity, is an aristocracy of brains with greater emphasis upon the development of our citizens as reasoning animals, the inevitable result being a greater number of individually responsible persons.

There is a great difference between the "intellectual snob" and the pseudo-intellectual who, because he lacks independent resourcefulness, fits into one of our robot educational patterns and struts without the capacity to expand his responsible thinking on his own initiative. The sheep will follow the sheep, and the larger the herd, the more like attracts like. Vast fortunes are being made because in America, probably more than in any other country, the robot state of mind is being fostered, perhaps not deliberately, but subtly, even unconsciously, and therefore more dangerously.

SOCIALIZED MEDICINE

Currently, there is a nation-wide debate on the question of political or socialized medicine versus free enterprise in American Medicine. The champions of political medicine have a great deal of government support, but at long last the American Medicial Association has come forward with an affirmative program designed to solve some of the difficulties instead of continuing in its original role of opposing proposed measures while offering nothing affirmative in their stead.

In relation to the controversy, the field of psychiatry occupies a unique position. Psychiatry itself, which grew out of the jails and the poorhouses, can scarcely be said to have quite as respectable an ancestry as other branches of medicine, which have progressed under the aegis of free enterprise in American Medicine. Without receipt of public sympathy and private philanthropy, 95 per cent of the practice of psychiatry has been state medicine for more than a hundred years.

As a matter of fact, free enterprise might well question itself as to whether it has shirked its obligations by sloughing off the care of the mentally ill and allowing psychiatry to get into the present-day state of affairs through political medicine.

There have been some good things and some reasonably good state institutions, but if we take the country as a whole, it is safe to say that only a small fraction of present-day knowledge in psychiatry is made available to the greater percentage of the patients in the six hundred thousand hospital beds already dedicated to the mentally ill of America. In some parts of the country these victims of political medicine are probably not even

receiving good board and room, to say nothing of scientific treatment.

The lack of progress in this example of political medicine is appalling, and to compare the average care of the mentally ill in this country with any other part of the world does not eradicate the public disgrace of the over-all picture.

The public should call for an up-to-date assay of results in psychiatry, and should think long and carefully before plunging head-long into anything that even resembles political handling of the other branches of medical care. Let the people demand first that the responsibility already assumed in psychiatry by state and political medicine be satisfactorily answered. Let the people demand that the ability of state medicine be demonstrated in its present responsibilities before going farther along the road toward political handling of medical care.

The research attack upon this greatest of all public health problems is pathetic. Support from public funds is a mere pittance compared with the research backing which has come to other fields in which free enterprise in American Medicine obtains. During the war period the already pitiful state efforts in the field of psychiatry shrivelled, leaving us in a position which compares most unfavorably with the psychiatric progress achieved up to twenty years ago by state medicine.

If the proponents of political medicine are really in earnest about improving public health, and if they are truly worried about the high percentage of rejectees on the military induction lines, let them look consistently at the fact that more than half of all the hospital beds in America are occupied by the mentally ill, and let them remember that approximately a third of the medical military rejectees, as well as approximately a third of the medical military dischargees, were in the field of psychiatry.

Why ask for new worlds to conquer when the obligations already belonging to socialized medicine have been so scandalously neglected? Why ask for more when a concentration of all their efforts and resources in this one field, which is already their own, offers the greatest single opportunity to bring health to the greatest number?

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

The American Board of Psychiatry and Neurology has now been in existence for twelve years. Recently I looked at my diploma from the board, and somewhat amusedly I noticed that it was number thirteen, which may designate me as an individual who would wisely have no opinions. On the other hand, I have watched the evolution of the board from the time its usefulness in raising standards was doubtful until the present day, when the board has established itself and carries ever-increasing responsibility toward the public, which it was primarily organized to protect, and toward the psychiatric profession, which it was intended to stimulate.

If training facilities are to match the present assiduousness of the board in the selection of candidates, someone will have to assume the function of a normal school for the training of more teachers and leaders in psychiatry. It has occurred to me that the Institute's research efforts and active clinical program provide a unique opportunity for work along this line, and within the limits of its facilities the Institute might combine its educational program with that of some university to offer normal school training for psychiatrists.

The field has suffered from too many, too wide, and too varied concepts of the responsibility of a psychiatrist, but somewhere, somehow, the men who are to enter the specialty must have the opportunity to direct their efforts more definitely in the still nebulous and bulky psychiatric knowledge. If I am correctly informed, there are those who are thinking seriously of settling down to determining the basic knowledge in psychiatric curricula without resorting to the "spoon-feeding" technique.

ON EDUCATION

This "spoon-feeding" technique of which I speak increasingly troubles me. Noting the undue prolongation of nursery methods of education into adult life, and specifically in my own specialty, I am disturbed to see practices in psychiatric education reminiscent of the techniques for adolescents.

We all know that in the process of learning, the older, more experienced, and possibly more learned individual determines what the neophyte should know, how much he should learn, and the relative importance of different kinds of knowledge. Figuratively speaking, the adolescent and the neophyte open their intellectual mouths, and like a Strasbourg goose swallow whatever has been chosen for them. This stuffing process must some day be replaced by more mature action on the part of the neophyte if he is going to survive. He must become capable of deciding, "This is what I want to take" and "This is what I want to leave alone." He must reach the point where he is full-grown, fully responsible, and avidly draining knowledge out of others without passively waiting for an invitation to drink.

Similarly, in the training of psychiatrists we should be building adult, resourceful men, who, having advanced beyond the point of the open intellectual mouth, can successfully forage in the intellectual forest and come back with intellectual security, aware of what they don't know, but always knowing where they can find what they need to know.

The persistence of some of the spoon-feeding in psychiatric education might well be a source of great concern to us in these days of accelerated educational programs. Let us make sure that in the process we are, with equal speed, developing in these men an adult sense of responsibility, character, and resourcefulness.

SOCIOLOGY AND THE FIELD OF PSYCHIATRY

If maximum progress is to be made in the field of psychiatry we will have to abandon old

concepts of isolationism. For one thing we should become students of sociology in order to understand the milieu in which everyday man is existing, and in our approach to sociological problems we might utilize a more scientific approach to good advantage.

In chemistry it is a well-known fact that sodium combined with chlorine under certain circumstances becomes a new chemical compound: sodium chloride, or ordinary table salt, which has properties not found in either sodium or chlorine individually.

In the field of sociology it seems to me that too much of our deductive reasoning has been on the erroneous assumption that two well-known sociological elements when brought together become a simple mixture of these two elements. A more logical assumption would be that something new is formed from two sociological elements, something with qualities entirely foreign to the primary ingredients, and something which must be dealt with accordingly.

New standards and new ways of thinking do not result in a mere mixture of the old, but in new situations out of which come new psychiatric problems calling for a new understanding.

PSYCHOSOMATIC MEDICINE

We in psychiatry are a little prone to adopt slogans and endorse "approaches." One of the newest of these is psychosomatic medicine. I am a little apprehensive that it is becoming a dictum with salesmanship and propaganda following in its wake instead of being a sphere of thoughtful, scientific investigation. Unless it is controlled, there is the possibility that it may become a cult with all the inherent danger of over-selling and superficial thinking, or a "specialty" without the actual qualities of a specialty. Already there are those who are "practitioners of psychosomatic medicine."

In the final analysis, the relationship between man's psychological processes and his body functions is nothing new, and if it is anything at all, it is so intrinsically part and parcel of all of psychiatry that it does not lend itself to the development of a special branch of the field. Here at the Institute over one hundred years ago the then head of this hospital was interested in and wrote on the subject of what is now referred to as psychosomatic medicine.

We at the Institute today feel strongly that the term is descriptive of the scientific approach to mental illness; further, we believe that real scientific research must start from the known and move into the unknown, and that the study of the soma will lead to a better understanding of the mind. Much of our research is in the coupling together of the soma and the psyche.

RESEARCH

With the conclusion of hostilities and the return of our personnel from the armed services, it is possible to resume research activities on our former scale. In my mind, efforts along this line will, in the long run, accomplish the greatest good for the greatest number of patients. I am appending a list of research projects undertaken during the past year, most of which are still under way.

Techniques in psychiatry are amateurish compared with what they must be and will be. Psychiatrists most certainly must delve deeper into biology, physics and biophysics, searching for the causes of mental illness and identifying man's psychological adjustment with physiologic and sociologic changes in living. We must not forget the many impressions which the human being is constantly receiving from outside himself. There must be a recording of every impression in the body itself, and that recording, as it becomes more intense and more extensive, becomes more permanent. If this be true and we improve our techniques sufficiently, we will find that there is no such thing as "mental illness" without a physical recording and accompaniment.

NEUROSURGERY

The advent of shock therapy initiated a rapid change in our psychiatric thinking which gave impetus to a search for other than psychological means of attacking mental disease. It is hoped that this search will continue without our abandoning the knowledge we have amassed along the educational and psychological lines, and that we may profit by combining knowledge instead of relinquishing one in enthusiasm for the other, which is too often the history of medical evolution.

Following close on the heels of shock therapy was the introduction of neurosurgery into the field of psychiatry, and the subsequent demand that all psychiatric hospitals reorganize their thinking and equip their plants for the procedures of brain surgery, which is bound to play a spectacular part in the psychiatry of the future, with the lobotomies or leukotomies merely the beginning of things to follow.

Steps already have been taken in this direction at the Institute, and we must proceed to envision further advances, which most certainly call for further development along the lines of the general hospital.

INSTITUTE OF CHILD PSYCHIATRY

One of the most significant occurrences in the history of the Institute was the announcement of the Institute of Child Psychiatry to be constructed on the property of the Institute of Living. We have long been interested in establishing facilities for the mentally ill adolescent and pre-adolescent, and it is gratifying to know that we are near a goal toward which we began working more than twelve years ago, when the Institute first admitted small numbers of children to see what could be accomplished under existing conditions. It is my feeling that work with children is one of the best possible investments in preventive psychiatry, and certainly children with personality deviations and habit disorders should receive as much consideration as children with disorders such as epi-

lepsy and feeblemindedness, both of which have received elaborate consideration and extensive public support. The spontaneous contributions which have been forthcoming in spite of the fact that no active campaign for funds has yet been undertaken are an indication of a public interest that may need only direction and stimulation. An Institute of Child Psychiatry is a most important part and promising development in the Institute's over-all plan for the provision of psychiatric care in all of its branches.

CONTINUATION CARE

As another part of our over-all plan, when and if funds are available, continuation care shall be provided for chronic cases away from the physical plant of the Institute, but under the general scientific direction of those who are engaged in the active therapies. It is my belief that although these patients must be physically separated from the acute cases of the so-called "recoverable illnesses," they should, nevertheless, not be regarded as irrevocably hopeless nor deprived of therapeutic facilities.

Erroneously, the mere fact that a patient happens to be in the latter decade of life brings forth the defeatist attitude, with the supposition that the recoverable mental illnesses are not those occurring in the latter years of life. Actually 12 per cent of these cases coming to us marked as irreversible seem to recover or improve markedly with proper treatment. It is my fond hope that with the procurement of funds for their care and study, the psychiatric sphere, including mental patients of advanced years, will show great promise and will lose its characterization of unfavorable prognosis.

THE SOLDIER

I firmly believe that we have been passing through an era of psychiatric sense and nonsense. All the sense cannot be credited to our specialty, nor can all the nonsense about psychiatry be laid at the door of psychiatry.

Marking every thought and field with psychiatric implications does not increase the importance of psychiatry, and the psychiatric adorning of perfectly normal psychological responses to a given circumstance does not necessarily cloak us with wisdom which will be enduring when exposed to the test of time. Apparently we seem to have passed the peak of extreme statements and ridiculous claims, but it behooves us to think very clearly about some of the important problems of the present day as they pertain to men demobilized from the armed services.

Only too often have we failed to realize that a man may have been so intensely engrossed in military efforts, and may have adjusted so successfully to the abnormal circumstances of war, that he finds it difficult to readjust himself quickly in body and mind to the old civilian circumstances.

Before jumping at the conclusion that he is a psychiatric problem or that he is sick in any way at all, we should ask ourselves the very pertinent question, "Is his physical and psychological condition the normal reaction which should be expected from him under the circumstances from which he is emerging?" Further, we should question ourselves as to whether or not we are harming him more than helping him by giving profundity instead of simple reassurance to his physical and psychological readjustment.

If a man who has been intense in his war experience returns to civilian life and, with bouncing enthusiasm and no particular psychological difficulty, takes up where he left off, we might very well suspect that he is the one who is sick.

Our standard of measurement during this transitory period needs revision. If a man does not rush back to a job and stick to it, we should be very slow to characterize his reaction as evidence of emotional instability or sickness. It would be well for us to remember that 90 per cent of all employees wish to change their jobs at any given time, but refrain from doing so through controlling factors outside of themselves. This desire to pick and choose one's job is part of the normal man, and if none of this were in his make-up, ambition and progress would be at an end. For once in his adult life, as a demobilized soldier, he is foot-loose and fancy-free, and even as you and I, he is being very human in his restlessness, making the most of a golden opportunity to indulge his human urges.

QUESTION OF PERSONNEL

Particularly during the war, the mental hospitals, along with the general hospitals and all other public services, suffered severely from lack of public support. There probably has not been a time in the last two or three decades when the public has experienced anything like the present-day difficulties in obtaining good medical care of any kind, and psychiatric care, especially.

Little short of a nation-wide upheaval will alleviate the personnel situation within the mental hospitals. I fully believe that one will come. In this connection I am increasingly impressed that the mental hospital will never be any better than the quality of its personnel, regardless of money expended on buildings and equipment.

Throughout the country, I see a great change in attitude on the entire question of the personnel within charitable institutions. At one time it was quite generally accepted that persons working in a charitable organization should do so at a great personal sacrifice and probably wind up their own careers as objects of charity for lack of compensation and provision for their future. To me, one of the most vicious policies has been to call upon employees of charitable organizations to work at less than the minimum wage, which in effect required them to donate part of their services. Happily, there is a growing opposition toward this type of payroll deduction and an increased feeling that, with few exceptions, money should remain in the pay envelope to be spent as the individual employee sees fit.

I congratulate the board of this hospital on taking the stand that members of its personnel should receive compensation based on their services and worth, and according to the amount they would receive for similar services in the community, leaving the employee to determine the charity to which he will contribute, and the amount of his contribution. I believe that this concept, which is recognized as legal, is destined to obtain universally.

CENSUS

Probably the most spectacular happening of the year has been the admission of 1,013 new patients in a single twelve-month period, particularly significant in view of the fact that the previous year's record of 852 seemed too large to be real to us at that time. A year ago it did not seem possible that we had accomplished what we had, much less that we could do more. However, the need became greater. Efforts on the part of the personnel increased, and methods had to be streamlined without reducing the quality or effectiveness of care. I know of no other group which has accomplished a similar feat during these extremely difficult times.

The answer to the question of how this was achieved is entirely simple. Against the trend of the times, when organizations were experiencing an ever-increasing turnover of personnel, our personnel have become more stable and more loyal. On April first there were materially more people who had been in our employ one year or more than there were a year ago. This same trend has been true for the last three years.

As I review the results obtained by the young people who make up our personnel, I was never more humble in being the captain of a team. Its members have done the impossible, far beyond my own ability to foresee!

ACADEMY STUDY OF CHILD HEALTH SERVICES

The American Academy of Pediatrics' Study of Child Health Services is about to begin its research in Indiana, and the work of obtaining the required information from hospitals, health departments, and individual doctors will soon begin.

This study is purely fact-finding in nature. The academy believes that no group is better qualified to inquire into the present status of pediatric facilities, or to take the lead in planning for the future, than the physicians who are charged with the responsibility of rendering that care.

The information will be obtained from physicians, dentists, hospitals, and all public and private agencies giving child health services. In October a short one-page questionnaire will be sent to every physician and dentist in the state. The identity of the doctor is not required in getting a true picture of the overall status of available pediatric facilities. The confidential nature of any information concerning a doctor's practice is fully realized, and the method of doing this study does not include an analysis of the individual doctor's practice.

The Council of the Indiana State Medical Association has given its official approval of the study. Similar action has been taken by the Indiana Pediatric Society and the Indiana State Board of Health. The success of the Study depends upon the response of the individual doctors and dentists. It gives the profession an opportunity to demonstrate its interest in and its concern for the kind of medical care our children are to receive in the future.

COME EARLY AND STAY LATE—MAKE A VACATION OF THE ANNUAL MEETING AT INDIANAPOLIS!

Dr. Gordon W. Batman reports that his committees for the 1946 Annual Convention of the Indiana State Medical Association are well advanced in their arrangements for this affair. Any member of the state association who fails to attend will be missing an opportunity for scientific contact and entertainment of the highest order. Doctors' wives are urged to attend, and a very comprehensive program has been arranged for them by the committee of the Woman's Auxiliary to the Indianapolis Medical Society.

High lights of the entertainment program are a theater party for doctors, wives, and guests, on Tuesday, October 29, at 9:00 P.M., in the Murat Theater, and the Annual Dinner on the evening of Wednesday, October 30.

Special entertainment features for members of the association are the Stag Party at 6:00 P.M., on Tuesday evening, October 29. This will follow the Golf Tournament and the Trap and Skeet Shoot held that afternoon, for which events prizes are to be awarded at the Stag Dinner.

Elsewhere in this issue is the announcement of the Instructional Course to be offered on Tuesday, October 29 (see page 458).

Also in this issue are notes regarding the program of events for the wives of members (see page 461). All members should plan to bring their wives to Indianapolis for the convention.

Hotel reservations should be made directly with the hotel of your choice, at once, as another convention conflicts with ours, but hotels are giving our membership preference on requests for rooms sent in now.

The general and sectional meetings are being planned to bring current medical and surgical problems before you. You owe yourself a date in Indianapolis for October 29, 30, 31, 1946. We shall look for you early.

ORDER YOUR TICKETS FOR THE 1946 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1946 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at Murat Temple, Indianapolis, is now complete. All classes are on Tuesday, October 29, 1946.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now!

INSTRUCTIONAL COURSE SCHEDULE

Hours	*Officers' Room*	*Candidates' Room 1*	*Candidates' Room 2*	*Directors' Room*	*Foyer*
11:00 A.M.	Diagnosis and Care of Rheumatic Fever Course 1	Office Treatment of Genito-urinary Conditions Course 6	Orthopedics in General Practice Course 11	Headache Course 16	Diagnosis and Treatment of Common Skin Diseases Course 21
1:00 P.M.	Infant Feeding Course 2	The Status and Use of Penicillin and Sulfa Drugs Course 7	Backache Course 12	Office and Bedside Heart Examination Course 17	Diagnosis and Treatment of Eye Conditions in General Practice Course 22
2:00 P.M.	Immunization Course 3	Office Laboratory Procedures Course 8	Diagnosis and Treatment of Common Skin Diseases Course 13	Management of the Elderly Course 18	Management of Diabetes Mellitus Course 23
3:00 P.M.	Prenatal Care Course 4	Treatment of Burns Course 9	Office Treatment of Anorectal Conditions Course 14	Psychological Management of Patients Course 19	Office and Bedside Heart Examinations Course 24
4:00 P.M.	Obstetrical Anesthesias Course 5	What to Expect from X-rays and X-ray Therapy Course 10	Office Surgery of Ear, Nose and Throat Course 15	Treatment of the Menopause Course 20	Management of Colitis and Constipation Course 25

Cut on dotted line.

APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

	11:00 A.M.	1:00 P.M.	2:00 P.M.	3:00 P.M.	4:00 P.M.
First choice...	No.:	No.:	No.:	No.:	No.:
Second choice.	No.:	No.:	No.:	No.:	No.:

(Insert course numbers plainly, please.)

Your tickets will be waiting for you at the Registration Desk, October 29, 1946.

Signed: .....M.D.

Address:.....

TWENTY-FIFTH ANNIVERSARY OF THE DISCOVERY OF INSULIN

On the occasion of the Twenty-Fifth Anniversary of the Discovery of Insulin, an International Diabetic Clinic will be held in Indianapolis, sponsored by Eli Lilly and Company in cooperation with the American Diabetes Association, at the Indiana University Medical Center, in Hurty Hall of the State Board of Health Building, from 2:00 to 5:00 P.M., on the afternoon of Monday, September 23, 1946.



Charles H. Best, M.D.

The meeting will be open to all interns and residents of Indianapolis hospitals, medical students, and the local medical profession. International significance is given to the meeting by the presence of outstanding notables in the field of diabetes, such as Dr. Charles H. Best, of Toronto, Canada, co-discoverer of insulin with Sir Frederick Banting. The various phases of diabetic care will be discussed.

Eli Lilly and Company will be host to Indiana physicians, and extend a cordial invitation to everyone.

This international clinic will probably bring together the largest number of physicians in Indianapolis in recent years.

PROGRAM

1. Dr. J. O. Ritchey, Professor of Medicine, Indiana University School of Medicine, Indianapolis—Address of Welcome.
2. Dr. Franklin B. Peck, Assistant Director of Medical Division, Lilly Research Laboratories, Indianapolis, and Secretary of the American Diabetic Association will introduce the following speakers:
   Dr. Moses Barron, Minneapolis, Minnesota.
   Dr. W. D. Sansum, Santa Barbara, California.
   Dr. G. H. A. Clowes, Research Director Emeritus, Lilly Research Laboratories, Indianapolis.
3. Dr. Charles H. Best, Professor of Physiology and Head of Physiology Department, University of Toronto, Toronto, Canada:
   "The Discovery of Insulin."
4. Dr. John R. Williams, Consultant in Medicine, University of Rochester School of Medicine, Rochester, New York:
   "Sir Frederick Banting."
5. Dr. Bernardo A. Houssay, Research Institute of Experimental Biology and Medicine, Buenos Aires, Argentina:
   "Etiology of Diabetes."
6. Dr. Joseph H. Barach, Pittsburgh, Pennsylvania, Retiring President of the American Diabetic Association:
   "Twenty-five Years of Insulin."
7. Dr. R. D. Lawrence, Physician-in-Charge of Diabetic Clinic, King's College Hospital, London, England:
   "Hemochromatosis and Diabetic Complications."
8. Dr. Carl F. Cori, Professor of Pharmacology, Biological Chemistry, and Head of Department of Pharmacology, Washington University, St. Louis, Missouri:
   "The Action of Insulin."
9. Dr. H. C. Hagedorn, Co-discoverer of Protamine Insulin, Gentofte, Denmark:
   "Modification of Insulin."
10. Dr. Elliott P. Joslin, Clinical Professor Emeritus of Harvard Medical School, Boston, Massachusetts:
    "Problems of the Future."

FEDERAL FUNDS MADE AVAILABLE FOR HOSPITAL CONSTRUCTION

The Hill-Burton Bill, providing federal aid through the states to local communities for construction and expansion of hospital facilities has passed both houses of Congress and been signed by the President.

Indiana's share of the $375,000,000 appropriation is $1,727,775 for 1947. The money will be used to assist in the construction of hospitals and health centers, and the expansion of existing hospital facilities.

The program, administered on a five-year basis, will upon completion give Indiana more than $8,600,000 for hospitals.

Anticipating possible passage of the Hill-Burton Bill, the last session of the General Assembly authorized the Indiana State Board of Health to conduct a survey of existing facilities in the state to determine hospital and health-center needs. Construction under the Hill-Burton Bill will be based only on demonstrated need as indicated by the survey completed a few months ago. Indiana was one of the first ten states to complete its survey.

Dr. L. E. Burney, state health commissioner, stated that while $1,727,775 is a small amount to meet overall Indiana hospital needs, it will serve to stimulate construction that otherwise could not be done. He said that the Division of Hospital and Institutional Services of the Board, and the Advisory Hospital and Health Center Planning Committee are prepared to work with the local community in developing plans to meet community needs. The Hill-Burton Bill sets aside $3,000,000 to be apportioned among all the states for plans and specifications. The board, he said, cannot give financial aid.

The legislation authorizes the Federal Government to pay one-third the cost of building or equipping new hospitals, the government's share of the aggregate planned cost to be $375,000,000 and the sponsors the remaining $750,000,000.

Sponsors may be state, city or other public governmental agencies or private nonprofit hospitals.

States will share in the fund on the basis of their needs, which will be ascertained through the ratio their per capita income bears to the national average. Other factors bearing on the determination of need will be population and value of products.

It was pointed out that the Hill-Burton Bill differs from most federal works programs in that under this bill, aid to the local community is channeled through the states. Previously, aid usually went directly to the local community.

ATTENTION, TRAP AND SKEET SHOOTERS!

An excellent Trap and Skeet Shoot is being arranged in connection with the annual session of the Indiana State Medical Association, from noon on, Tuesday, October 29, 1946, with desirable prizes, and all events for all classes of shooters are planned, so that you will shoot in competition with those of your skill and experience and thereby have a chance to win a prize if you "get hot" that day. If you wish to shoot skeet or trap, fill out this questionnaire and send it to the undersigned. Due to the scarcity of shells it must be known in advance that you desire to participate in the shoot, so provisions can be made. If you don't sign up, and don't send in this notice, there will be no possibllity of your shooting. Unless applicants sign up now and "pronto," no shoot can be arranged.

APPLICATION BLANK

(Cut on dotted line)

(1) I desire to shoot trap——, skeet——, or both——.

(2) I expect to use 12 ga.——, 20 ga.——, shells at skeet.

(3) Number of shells expected to be used: 50——, 100——.

(4) Number of 12-gauge trap shells to be used by me: 50——, 100——.

(5) I would like to attend the luncheon at Clubhouse of the Gun Club at the time of shoot: Yes——. No——.

(6) Which do you prefer, skeet——, trap——, or both——?

Mark each choice with an "X." Fill out this coupon and mail it immediately to:

H. M. BANKS, M.D.,
1604 N. Capitol Avenue,
Indianapolis 7, Indiana.

ATTEND
WOMAN'S AUXILIARY MEETING

Murat Temple

Indianapolis

October 29 and 30, 1946

The Woman's Auxiliary to the Indianapolis (Marion County) Medical Society has made special effort in an endeavor to reach every physician's wife with an individual invitation to attend the activities of the Woman's Auxiliary to the Indiana State Medical Association, held in conjunction with the annual session of the Indiana State Medical Association, at Indianapolis, October 29 and 30, 1946. The committee realizes, however, that regardless of these efforts some of the women may not have received a card, and a cordial invitation is hereby extended to all of you to attend this meeting.

There has been a slight change in the original plans, and the luncheon that was scheduled for the Indianapolis Athletic Club, Wednesday, October 30, will be held at the Columbia Club instead.

The program is as follows:

Tuesday, October 29, 1946

8:30 A.M. Registration begins—Murat Temple.
A group of our members will be at the door to receive you.

1:00 P.M. Meeting of the State Board Members—Murat Temple.

6:00 P. M. Dinner for all women attending the convention (Halloween Party)—Athenaeum

— — followed by — —

8:30 P.M. Entertainment for physicians and wives at the Murat Theater—just across the street.

Wednesday, October 30, 1946

10:00 A.M. Business Meeting for Auxiliary members—War Memorial Building—honoring Members at Large.

12:00 Noon Luncheon—Columbia Club.
Speaker: N. K. FORSTER, M.D., Hammond, immediate past president of the Indiana State Medical Association.
Bridge for those who wish to play.

7:30 P. M. Annual Dinner for physicians and wives—Murat Temple.
(Dinner $2.50; Bridge Luncheon $1.50; these prices subject to change without notice.)

Those of you who did not receive a reservation card will kindly write to Mrs. Henry Leonard, 3916 Washington Boulevard, Indianapolis 5, Indiana, informing her of the activities you expect to attend. *Please make reservations before October first,* for our space is limited.

Also make your hotel reservations immediately!

Each member of our local auxiliary is doing everything possible to make this convention the best ever, and we want you to enjoy every minute of it.

Mrs. Emmett B. Lamb, *President,*
Woman's Auxiliary to the Indianapolis
(Marion County) Medical Society.

Mrs. John Carmack, *Chairman,*
General Convention Arrangements.

MAKE YOUR HOTEL RESERVATIONS IMMEDIATELY

for the

ANNUAL SESSION OF THE INDIANA STATE MEDICAL ASSOCIATION

October 29, 30, 31, 1946

Indianapolis

Military News

A lieutenant-colonel at the time of his discharge from the Army, Dr. Fred C. Reynolds, of Indianapolis, has become associated with Dr. J. Albert Key, in Saint Louis, Missouri.

Recently discharged from the Army, Major Gilbert J. Himebaugh has begun the private practice of medicine in Veedersburg. Doctor Himebaugh served for two and one-half years in the Army, one year of which was spent on Okinawa.

Lieutenant William M. Huse, of Indianapolis, who was recently at home on a furlough, has been transferred from Madigan General Hospital to Fort Sam Houston, in San Antonio, Texas, where he expects to remain for about eight weeks.

Dr. Thomas James, Jr., formerly of Vincennes, has opened offices in Huntington, for the general practice of medicine, following his recent release from service. Doctor James entered the Navy on January 1, 1943, and was discharged February 1, 1946. He served for two years in the Pacific Theatre.

Major Charles O. McCormick, Jr., of Indianapolis, has been released from the service, and has taken up his practice of medicine in the Hume Mansur Building. With the Headquarters of the 5th Army, Doctor McCormick spent four years in the service, and his tour of duty took him to Africa, England, and Italy.

Following his recent release from the Medical Department of the Navy, and the Marine Corps, Lieutenant William J. Gerding, of Fort Wayne, has moved to San Diego, California. Doctor Gerding served in China, in the Pacific, and on the West Coast during his connection with the Medical Department.

After thirteen months in England and France, on the orthopedic service of the 122nd, the 91st, and the 242nd General Hospitals, Dr. Horace Norton, of Plainville, returned to the United States and was transferred to the Lovell General Hospital, at Fort Devons, Massachusetts, where he served as assistant chief of the orthopedic service. He was there until the hospital closed, and was then separated from service after three years in the Army. Doctor Norton is on terminal leave at present.

Lieutenant Colonel E. W. Williams, of Columbus, was recently discharged from the Army, after serving for three years as a psychiatrist at the station hospital at Fort Knox, Kentucky.

A veteran of World War II, Dr. Leo M. Smith, formerly of Portland, has purchased a residence and office in Ellettsville, to begin the private practice of medicine there following his recent discharge from service.

Captain Keith R. Ruddell, of Indianapolis, was separated from the service on June fifteenth, after three years with the Army. Doctor Ruddell was located at Springfield, Missouri; Gardiner General Hospital, in Chicago; and was chief of surgery at Fort Sill, Oklahoma.

Recently discharged from the Army Medical Corps, Captain James E. Engeler, of Lebanon, has become affiliated with the Arnett-Crockett Clinic, in Lafayette. Doctor Engeler served with the Medical Corps for thirty-seven months, sixteen months of which were spent overseas.

Released from active duty in May, Captain Charles H. Proudfit, of Mishawaka, has opened an office for the practice of obstetrics and gynecology in South Bend. Doctor Proudfit practiced in Mishawaka from 1935 to 1940, when he went to the Mayo Clinic, in Rochester, Minnesota, for postgraduate work. He entered the Army in July, 1944.

Lieutenant Colonel Wayne Carson, of Indianapolis, has resumed his practice of surgery in the Hume Mansur Building, after four years of service in the Army. Doctor Carson spent approximately ten months overseas, where he served as chief surgeon of the 27th General Hospital, in Tokyo. He also served in the Philippine Islands and on Okinawa.

Lieutenant Herbert F. Sudranski, of Indianapolis, has returned to civilian status and has resumed his practice of opthalmology in the Hume Mansur Building. During his twenty-seven months' service in the Navy, Doctor Sudranski was stationed at Camp Peary, Virginia; Camp LeJeune, North Carolina; Astoria, Oregon; St. Albans, New York; and Brooklyn, New York.

Another Indianapolis physician who is now on duty in the Pacific is Lieutenant James S. Fitzpatrick. He is with the 332nd General Dispensary.

Recently discharged from the Navy, Lieutenant Wendell E. Covalt, of Muncie, has opened an office for the practice of surgery in Muncie.

Lieutenant (j.g.) E. M. Beck, of Indianapolis, currently with the First Marine Division in China, reports that he expects to return to civilian status soon.

With the 98th General Hospital, Captain Charles F. Gillespie, of Indianapolis, writes from Munich, Germany, that he expects to be released from service in the fall.

Recently released from the Army, after three years' service, most of which was spent in the ETO, Dr. John Caton, of Indianapolis, has accepted a position as resident house physician at the Emhardt Memorial Hospital, in Indianapolis.

Captain John P. Gentile, of New Albany, has joined the staff of the Veterans Administration, at Lexington, Kentucky. Doctor Gentile served with the 81st General Hospital and 118th Infantry Regiment in the ETO.

A former resident physician at the Indianapolis City Hospital, Dr. Norman R. Cook, of Indianapolis, has been promoted to captain in the Army Medical Corps, at the Mason General Hospital, in Brentwood, New York, where he is chief of one of the sections of the neuropsychiatric service. Doctor Cook entered the Army in April, 1945.

Dr. W. D. Bretz, Huntingburg, had four sons in the European Theatre of War. Dr. John M. Bretz, on the staff of Welborn Memorial Baptist Hospital, Evansville, landed in Normandy with the 83rd Division on D-2, was awarded a Bronze Star and Purple Heart; W. D. Bretz, Jr., a lawyer recently located in Kokomo, with the 87th Division was also awarded a Bronze Star. The two others saw extensive service in Italy and the Battle of the Bulge.

Recently discharged from the United States Army Air Force, Dr. N. C. Johns is to be associated with Dr. F. H. Kelly, of Argos. Doctor Johns is a graduate of the University of Chicago; he spent his internship at Mercy Hospital, at the University of Pittsburgh; and he had a six months' surgical residency in the West Suburban Hospital, in Chicago. After three years' active service in the Army Medical Corps, Doctor Johns took a postgraduate course at the University of Illinois Research Hospital.

After two years and seven months in the Army, Major Lawson J. Clark, of Indianapolis, has been released and has resumed his practice of obstetrics in Indianapolis.

Recently released from the Army, where he was battalion surgeon for the 497th Field Artillery Battalion, Dr. B. Kemper Westfall, of Indianapolis, has opened an office at 1 West 28th Street.

Lieutenant Jack W. Hannah, of Wakarusa, opened his office there recently, following his discharge from the service. Doctor Hannah served for approximately five years in the United States Public Health Department, with the Coast Guards.

Captain Robert A. Craig, formerly of Indianapolis, has become associated with Dr. Fred O. Clark, at Syracuse. Doctor Craig was discharged from the Army recently, after three years' service, two of which were spent in the Philippines.

Recently discharged from the Navy, Dr. Clifford E. Ernst, of Indianapolis, has announced his return to the general practice of medicine, at 2611 West Michigan Street. A veteran of both the European and Asiatic theatres, Doctor Ernst served as a medical officer aboard the *U.S.S. General Tasker H. Bliss.*

Forty-six months in the Army Medical Corps have been completed by Captain Richard E. Estlick, of Fort Wayne, whose service included duty with the North Atlantic Wing Base of the Army Air Forces, in Labrador. For the past year and a half Doctor Estlick has served as assistant chief of the E.N.T. clinic at the Wakeman General Hospital, at Camp Atterbury. He has reopened his office at 432 Wayne Pharmacal Building, in Fort Wayne.

Commander Lawrence S. Bailey, of Zionsville, who was recently discharged from the Navy, where he spent four years, has received a citation from the Navy Department "For distinguishing himself by excellent service as Senior Medical Officer of the Twenty-Second Special Construction Battalion, in charge of malaria control for said battalion at U.S.N. Base, Manus, from 18 May, 1944 to 31 July, 1945. Through his professional skill, capable leadership and unremitting efforts, while located in an area in the southwest Pacific, where malaria is prevalent, he successfully organized and maintained malaria control at such a high point of efficiency that no cases of malaria infection occurred within his battalion during a period of sixteen months. For his conduct throughout he is commended and authorized to wear the Commendation Ribbon." Doctor Bailey recently reopened his office in Zionsville.

Captain David J. Smith, of Indianapolis, has been separated from service after thirty months in the Army. He spent a year in the ETO with the 89th Infantry Division. Doctor Smith is now a resident in surgery at the Methodist Hospital, in Indianapolis.

Recently discharged from the Navy Medical Corps, Lieutenant W. K. Sloan has become associated with Dr. George A. May, of Madison. Doctor Sloan spent two years overseas, in the Pacific theatre. He is a graduate of the University of Louisville School of Medicine, in 1943, and served his internship in San Francisco, California.

Formerly of Indianapolis, Captain Jerome M. Korn has become associated with Dr. Harry L. Kahan, in Gary, upon his release from the service. Doctor Korn served for thirty months, twenty-one months of which were spent in the ETO, where he participated in five campaigns, with the 47th Field Hospital. He became company commander of the 449th Medical Collecting Company, after V-E Day.

Major Welbon D. Britton, formerly of Indianapolis, has located in Montezuma following his recent release from the service. Doctor Britton was in the Army for thirty-four months, and served in both the European and Pacific theatres. With Patton's 3rd Army, he served in Europe for eighteen months, and then went to the Pacific area where he served in New Guinea, Luzon, and Leyte.

Following his recent release from active duty, Major Frank B. Bard has resumed the practice of medicine at Crothersville. From April 27, 1942, to May 7, 1946, Doctor Bard served with the 306th Medical Battalion of the 81st Infantry Division. Overseas from May 14, 1944, to January 20, 1946, he served in the western Pacific and the southern Philippines. He was awarded the American Theatre Service Medal, the Asiatic-Pacific Service Medal, the Philippine Liberation Medal with one bronze star, and the Victory Medal.

Two newcomers to the medical profession in Evansville are Dr. Thomas J. Moran, formerly of Pittsburgh, Pennsylvania, and Dr. Gilbert T. Hyatt, formerly of Fall River, Massachusetts. Both are veterans of World War II. Doctor Moran was released from the United States Naval Reserve recently as a lieutenant commander, after four years in the service. He was with Mobile Hospital Unit Five, and served in New Caledonia, at the Great Lakes Naval Training Station, and at Fort Eustis, Virginia; and was in Panama just prior to his release from service. Doctor Hyatt served for five years and four months in the Army Medical Corps. He spent eighteen months in the ETO. Both Doctor Moran and Doctor Hyatt are connected with the Welborn Hospital, in Evansville.

Captain E. N. Walsh, formerly of Whiting, is now located at the Scott-White Clinic, in Temple, Texas, where he is head of the dermatology staff. Doctor Walsh served as superintendent of a Panama hospital during his military service.

Major William R. Thompson, of Winamac, has become associated with Dr. T. E. Carneal, at the Carneal Hospital, in Winamac. Now on terminal leave, after three years of military service, Doctor Thompson spent two years in an Army hospital in England.

Captain Nolan A. Hibner, of Monticello, recently released from service, has taken over the practice of Dr. H. B. Gable, of Monticello, who is taking an extended vacation. Doctor Hibner is a graduate of the Indiana University School of Medicine, and served with the 64th Station Hospital in California, and later with the 374th General Hospital in the South Pacific area.

Announcement has been made by Dr. Guy A. Owsley and Dr. Charlotte Owsley, of Hartford City, of the association of Dr. Bryce P. Weldy, also of Hartford City, with the Owsley offices and practice. Both Dr. Guy Owsley and Doctor Weldy have recently returned from military service. Captain Weldy served as county coroner prior to his military service, and has taken special work at New York Polyclinic following his release from service. Doctor Owsley, a colonel in the Army Medical Corps, was reordered to active duty on July first, at the Borden General Hospital, Aural Rehabilitation Center, at Okmulgee, Oklahoma, until August fifteenth, when he will go to the Walter Reed General Hospital Rehabilitation Center, at Washington, D. C.

Separated from the service on May sixteenth, after twenty months of naval service, Lieutenant Loren F. Schmidt (j.g.), formerly of Indianapolis, is residing temporarily in West Terre Haute. During the greater part of the time he was in service, Doctor Schmidt was in the Asiatic-Pacific Theatre. He reported to active duty at the United States Naval Hospital, Corona, California, on September 10, 1944, going from there to Guam with the 103rd Seabees after spending some time on the *U.S.S. Shasta*, and later with the Sixteenth Special Seabees. He was then transferred to the United States Naval Hospital at Guam, where he served as ward medical officer of sick officers quarters. He wears a battle star received for service aboard the *Shasta* during the Okinawa campaign; the *Shasta* being an ammunition ship which re-armed Colonel Halsey's Fleet, and which encountered a typhoon June 5, 1945, off Okinawa, lasting ten hours.

Captain Jack M. Lockhart, of Indianapolis, has accepted a two-year residency at the Nichols General Hospital, in Louisville, Kentucky. Doctor Lockhart was released from service on June twenty-second, after thirty months' service, eighteen of which were spent in the ETO with the 100th Infantry Division.

After forty-one months' service, Captain Edwin R. Eaton, of Indianapolis, has been released from the Army. For the past seventeen months Doctor Eaton has served as assistant chief of general surgery at the Wakeman General Hospital. Prior to that he was with the 63rd Infantry Division and the 114th Evacuation Hospital. At present he is at the Methodist Hospital, in Indianapolis, where he has accepted a residency in surgery.

Dr. J. William Wright, Jr., has been discharged from the Army with the rank of major. He served for nearly three years in the Ear, Nose and Throat Department of the field hospital at Buckley Field, Denver, Colorado. He is now associated with his father, Dr. J. William Wright, Sr., and expects to accept a residency in Ear, Nose and Throat about December.

Announcement of the opening of an office, at 201 South D Street, in Marion, for the general practice of medicine, has been made by Dr. John G. Rhorer, following his recent release from the Navy. Doctor Rhorer entered the Navy in January, 1944, as a lieutenant (junior grade), and was promoted to senior grade in June, 1945. He served for several months at the induction station at Camp Shelby, Mississippi, and then was on sea duty for one and one-half years, which included a cruise to Japan.

Captain John B. Westfall, of Lebanon, has recently been released from service, after spending almost three years at numerous posts. He was on the surgical service at Gardiner General Hospital, in Chicago, for a short time, and at the Mayo General Hospital, in Galesburg, Illinois, for fifteen months. He then spent five months at the Fort Knox Regional Hospital for parallel training, going overseas with the 304th General Hospital, and remaining at Tinian, in the Marianas, for seven months as part of a large hospital center—five general hospitals—awaiting an invasion of Japan, which never materialized. He then returned to the United States, spending a few months at Billings General Hospital, and the rest of his Army service as a transport surgeon at San Francisco. He was fortunate in having had hospital service during his entire Army connection, being on the surgical service throughout. Doctor Westfall is on terminal leave at the present time, and plans to return to practice as soon as he finds a suitable location.

Captain Dan L. Urschel, of Mentone, returned from the service in July, and plans to reopen his office in Mentone on September sixteenth, where he will practice internal medicine. Doctor Urschel was stationed at the Battey General Hospital, in Rome, Georgia, and at the Walter Reed General Hospital, in Washington, D.C., during his military career.

Captain John H. Nill, of Fort Wayne, has entered private practice at 1024 Barr Street, Fort Wayne, following his recent discharge from the Army Medical Corps. A graduate of the Indiana University School of Medicine, Doctor Nill served his internship at the St. Joseph Hospital, in Fort Wayne. He entered the service in July, 1943, and was sent first to the Medical Field Service School, at Carlisle, Pennsylvania, and then to Camp Carson, Colorado. He then was assigned overseas, where he spent twenty-three months in the Pacific area. For the past six months he has been stationed at the Camp Stoneman Hospital, Colorado.

A recent visitor in THE JOURNAL office was Dr. Everett L. Kalb, of Indianapolis, who has been spending his terminal leave visiting his colleagues and catching up with things. A battalion surgeon with the 95th Division, Doctor Kalb was stationed in the European Theatre, and was in the Metz and Saar campaigns. After combat he was reassigned as battalion surgeon to the 29th Division, going from there to the 17th Cavalry Reconnaissance Squadron. Among Doctor Kalb's awards were the Combat Medics Badge, the Bronze Star, and an ETO ribbon with three battle stars. Announcement has been made of his appointment as medical director of the Rapid Treatment Center, at the Market Street Health Center, in Indianapolis.

Major William S. Yocum, formerly of Coal City, recently was awarded the Silver Star for gallantry in action on September 10, 1944, near Arnaville, France, and received the following citation: "When heavy casualties were sustained following an assault crossing the Moselle River, (Captain) Yocum, the battalion surgeon, went forward under intense enemy artillery and small arms fire to administer medical care and to supervise the evacuation of the wounded across the river to a place of safety. Disregarding personal safety, (Captain) Yocum then supervised the movement of his aid station across two hundred yards of open terrain and established a safe route of evacuation. His conspicuous courage and diligent efforts were the means of saving many lives, reflect great credit on himself, and are in keeping with the highest traditions of the Medical Corps." Doctor Yocum has opened an office for the private practice of medicine at 738 Broadway, in Gary.

News Notes

Dr. Russell Wood, of Oakland City, has purchased the Maternity Hospital in that city, and plans to establish his office there.

Announcement has been made of the addition of Dr. Alonzo A. Petty, of Dayton, Ohio, to the staff of the Madison State Hospital, as of September first.

Dr. Carl D. Huckleberry, of Danville, has been commissioned a captain in the Indiana State Guard, 3rd Infantry. Doctor Huckleberry was connected with the Mayo Foundation before entering general practice in Danville.

A two-day conference on the treatment of epilepsy was held in Indianapolis recently by the members of the Indiana Society for Crippled Children, who met with Ohio officials. Dr. Walter C. Van Nuys, of New Castle, superintendent of the Indiana Village for Epileptics, and Dr. Earl W. Mericle, of the Indiana University School of Medicine staff, participated in the conference. Dr. Jerry Price, of New York, who is medical consultant in epilepsy, also took an active part in the program.

INTERNATIONAL SURGICAL ASSEMBLY

An international surgical assembly, sponsored by the United States chapter, International College of Surgeons, will be held in Detroit, Michigan, October 21, 22, 23, 1946. An intensive clinical and didactic program by world authorities will be presented (see page xxxvi). All medical men and women in good standing are cordially invited. Program and information on the Assembly, and the primary qualifications for Fellowship in the International College of Surgeons, are available by writing to L. J. Gariepy, M.D., Secretary, 16401 Grand River, Detroit 27, Michigan.

The State Board of Health has announced that C. Merle Bundy, M.D., of Salem, has temporarily replaced Dr. Carl C. Kuehn as director of the Board's Division of Tuberculosis Control. Doctor Kuehn has been granted a leave of absence to take advanced study in public health at the University of Michigan. Doctor Bundy graduated from the Indiana University School of Medicine in 1942. He saw active service during the war with the United States Coast Guard, aboard the *U.S.S. Everett.* Since his release from the Coast Guard he has taken advanced training in tuberculosis control.

Dr. L. W. Tennant, of Larwill, has sold his home in Larwill, and plans to move to his new home in Fort Wayne, and retire.

Dr. D. W. Fosler, of Indianapolis, has devised a diamond-point glass ampule cutter which should prove a boon to the physician's office, for it cuts the ampule without shattering and thus practically eliminates cutting fingers.

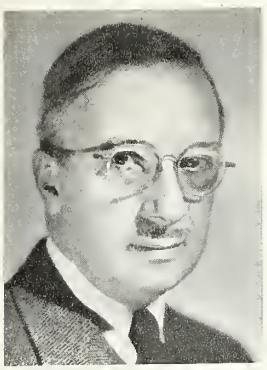
Dr. J. H. Stygall, of Indianapolis, attended the annual meeting of the American College of Chest Physicians, held in San Francisco, in July, and was re-elected regent for Indiana and Illinois for a three-year term.

The Lafayette Academy of Medicine held its annual social meeting at the Tippecanoe Country Club, on Lake Shafer, on July twenty-sixth. A business meeting in the evening followed an afternoon of golf and entertainment. The committee in charge of arrangements included Drs. C. J. Trout, chairman, M. G. Frasch, R. A. Flack, and W. W. Washburn, all of Lafayette.

Dr. Alexander Hamilton, of Frankfort, was awarded first prize for a three-chapter short story by the American Physicians Literary Guild, in conjunction with the American Medical Association, at San Francisco, recently. The story was entitled "The Doctors Mascarade." Doctor Hamilton also was awarded third prize for a poem he wrote.

Billings General Hospital at Fort Benjamin Harrison will be opened as a temporary veterans' institution on October first, according to a recent announcement. At a meeting of Army officers and Veterans Administration officials, plans for the Army's release of the hospital were completed recently. Included with the transfer of the structures are medical supplies, surgical and other hospital equipment, and protective and maintenance equipment. The temporary hospital will be operated until construction of a new veterans hospital in the Indianapolis area is completed. Present plans are to the effect that the new hospital will be completed next year. The hospital is equipped for a two-hundred-fifty-bed capacity at present, and plans are being made to increase that number to five hundred as more beds become available. Four hundred employees will be needed by October first, and eventually a staff of six hundred will be required.

Two distinct honors have been conferred upon Dr. Raymond C. Beeler, of Indianapolis: He took office as president of the American Roentgen Ray Society on September sixth, at a week's meeting held at the Netherland-Plaza Hotel, in Cincinnati, where he was installed. Although not present at the American College of Radiology, held in San Francisco recently, he was elected to a four-year term as a member of the Board of Chancellors of that organization.



Raymond C. Beeler, M.D.

L. W. Frame, M.D., recently of Lawrenceville, Illinois, has been named Medical Director of the new State Board of Health branch office, in Washington. He will take charge immediately of the office serving southwestern Indiana.

Doctor Frame has had wide experience in public health in West Virginia, Tennessee, and Illinois, since 1936. He headed the first defense zone health department organized in Illinois, a post comparable to the one he will hold in Indiana.

MEETING OF THE ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES

The Association of Military Surgeons of the United States will hold its convention in the Ball Room of the Book-Cadillac Hotel, in Detroit, Michigan, October 9 to 11, inclusive. Highlighting the initial session will be the Presidential Address, delivered by Colonel Ervin Abel, the president of the organization; addresses by the two Surgeons General, Major General Norman T. Kirk, of the United States Army, and Vice Admiral Ross T. McIntire, of the United States Navy; Dr. Thomas Parran, of the United States Public Health Service; and Major General Paul R. Hawley, of the Veterans' Administration. Physicians, surgeons, dentists, veterinarians, and nurses are invited. There is no registration fee. All planning to attend are urged to send in their reservations at once to Colonel Burt R. Shurly, 1005 Stroh Building, Detroit 26, Michigan.

After a four-year Fellowship in Surgery at the Mayo Clinic, Dr. Ralph E. Blackford has returned to Indianapolis, where he will practice surgery.

INDIANA ARTISTS

Several members of the Indiana State Medical Association had entries at the Eighth Annual Exhibition of the American Physicians Art Association, held at the War Memorial Opera House, in San Francisco, July 1 to 5, 1946, and Dr. A. Hamilton, of Frankfort, received an Award of Merit for his oil painting, "The Bad Lands." He also exhibited another painting, "The Old Bridge." Other entries were as follows: "Study in Sunlight—Brown County," and "Pioneer Mansion," both photographs by Dr. John H. Hare, of Evansville; "Shipmates," book of drawings by Dr. Philip Todd Holland, of Bloomington; and "Captain for A Day," photograph by Dr. Charles F. Leich, of Evansville.

"One cannot practise medicine alone, and practise it early and late, as so many of us have to do, and hope to escape the malign influences of a routine life."—*Sir William Osler.*

PROGRAM FOR ELEVENTH DISTRICT MEDICAL SOCIETY

The eleventh District Medical Society will hold its annual meeting at the Veterans' Hospital, in Marion, on September eighteenth. The following program has been arranged:

10:30 A.M. Clinical Staff Conference.
Presentation of Cases and discussion, E. S. Post, M.D., Chairman; and Clinical Director, Veterans' Administration Hospital, Marion, Indiana.

12:00 Noon Luncheon.

2:30 P.M. "Out-patient Services to Veterans." (Bring your questions.)
D. R. Adams, M.D., Chief, Out-Patient Service. Veterans Administration, Regional Office, Indianapolis.

3:00 P.M. "Mental Hygiene."
S. T. Ginsberg, M.D., Chief, Acute Service, Veterans' Administration Hospital, Marion.

3:30 P.M. "Psychosomatic Medicine."
David A. Boyd, Jr., M.D., Professor of Psychiatry, Indiana University School of Medicine, and consultant at Veterans Administration Hospital, Marion.

6:30 P.M. Picnic Dinner.

1910 CLASS REUNION

A reunion of the 1910 class of the Indiana University School of Medicine will be held during the annual session of the Indiana State Medical Association, with a luncheon at 12:00 noon at the Athenaeum, Wednesday, October 30, 1946. Of the fifty-nine graduates, forty-three are still living. Dr. A. M. Hetherington, of Indianapolis, is the president of the class, and Dr. O. D. Ludwig, of Indianapolis, is the secretary.

Dr. Leon T. Cox has moved from Fountain City and established an office at 36 South Eighth Street, in Richmond.

Dr. John E. Kelly, formerly chief medical officer of the Veterans' Hospital at Dayton, Ohio, has been appointed as superintendent of the Veterans Administration Hospital at Fort Benjamin Harrison. Eugene K. Ricker, formerly supply officer of the Veterans' Hospital, at Downe, Illinois, has been named as executive officer at Fort Harrison. At present this hospital has a capacity of two hundred fifty beds, with possible expansion in the near future. The hospital is expected to be in operation by October first, if sufficient personnel can be had by that time.

Dr. Herbert M. Rhorer, of Kokomo, was elected a trustee of DePauw University, at the North Indiana Conference, for a three-year term. Doctor Rhorer took his pre-medical training at DePauw, and received his degree at Northwestern University. He has been practicing in Kokomo for twenty-five years.

The Veterans Administration in Washington, D.C., recently announced acquisition from the War Department of the Baer Field Hospital, in Fort Wayne, Indiana, for use on a temporary basis. The administration reported that the hospital will be activated at once as a veterans institution, and will be kept in service until a new, two-hundred-bed hospital, which has been approved for Fort Wayne, is erected. The Baer Field Hospital was a temporary general surgical hospital for the air forces.

RURAL MEDICAL CONFERENCE HELD AT PURDUE UNIVERSITY

More than two hundred persons attended the first Conference on Rural Medical Care, held at Purdue University, West Lafayette, on August first, under joint sponsorship of the Committee on Rural Medical Care of the Indiana State Medical Association, the Rural Health Committee of the Indiana Farm Bureau, and the Department of Agricultural Extension of Purdue University.

Dr. F. S. Crockett, of Lafayette, chairman of the Committee on Rural Medical Service of the American Medical Association, presided. Dr. J. E. Ferrell, of Fortville, president of the Indiana State Medical Association, who has been a country practitioner for forty-three years, spoke on "The Practice of Medicine in Rural Areas."

In discussing the rural medical care problem, Dr. Ferrell said, in part:

"One might say that country practice in years gone by was the finishing school for the young doctor. Ofttimes the young medic would practice in a rural community, gaining knowledge and training until he felt capable of establishing himself in a larger and busier urban center. There many of these medics became our best physicians and surgeons, and no little credit should be given to the basic training they received as country practitioners.

"In my opinion, this type of training for beginning doctors was a very good thing. Could it not be termed a rotating service? And might it not be a solution of the present problem if medical school graduates were required to practice a year or two in a rural community as a part of their education?"



First row (left to right), Dean Harry J. Reed, Dr. Norman Gardner, and Mrs. Alice Womacks, member of the Indiana Farm Bureau Health Committee.

Second row, Dr. Thurman B. Rice, Dr. Harlan English, and Dr. L. E. Burney.

Eight speakers, including Dr. L. E. Burney, state health commissioner, and Dr. Thurman B. Rice, professor of bacteriology and public health, Indiana University School of Medicine, covered all angles of rural health needs. At the conclusion of the speaking program, each county was requested to name a rural health committee to make a study of local medical care needs, this committee to be prepared to present its local problems at a later conference. The data will be analyzed by discussion groups and a definite plan of procedure will be worked out.

Dr. Norman H. Gardner, of East Hampton, Connecticut, and Dr. Harlan English, of Danville, Illinois, chairman of rural medical service committees in their respective states, were guests at the meeting.

In addition to the physicians already named, the following were present: Drs. H. N. Smith, Brookville; Stuart R. Combs, Terre Haute; George V. Cring, Portland; L. W. Frame, Washington; Daniel C. Barrett, Columbus; William D. Weis, Crown Point; Wendell C. Anderson, Valparaiso; H. M. Shultz and George H. Carew, both of Logansport; M. E. Glick, Kentland; A. E. Stinson, Rochester; C. H. Mayfield, Reynolds; Will J. Martin, Kokomo; T. S. Schuldt, Pierceton; C. F. Blankenship, Chicago; C. R. Clarke, Auburn; E. M. Conrad, Anderson; William M. Hepburn, West Lafayette; Harry E. Klepinger, Lafayette; Walter Stoeffler, George Brother, J. W. Jackson, Merle Bundy and Martha O'Malley, all of Indianapolis, and Ray E. Smith, Indianapolis, executive secretary of the Indiana State Medical Association.

INDIANA UNIVERSITY NEWS NOTES

The appointment of three new members and promotions of five other members of the faculty of the Indiana University School of Medicine, in Indianapolis, have been announced by President Herman B Wells.

The new faculty members are Drs. Earl W. Mericle and Charles K. Hepburn, both Indianapolis physicians, as assistant professor and instructor, respectively, in the Department of Neurology and Psychiatry; and Dr. Clifford L. Williams, director of the Indiana Council for Mental Health, and former superintendent of the Logansport State Hospital, as assistant professor of neurology and psychiatry. Dr. John Greist was also made an assistant professor in this department, being transferred from the Department of Medicine.

Dr. C. P. Clark was promoted from associate to clinical professor of ophthalmology, and Dr. G. J. Garceau from associate to professor of orthopedic surgery. Other promotions include Drs. William H. Headlee from assistant to associate professor of parasitic diseases; H. R. Hulpieu from associate to professor of pharmacology; D. E. Bowman from assistant to associate professor of biochemistry.

The additions in the faculty of the medical school's Department of Neurology and Psychiatry, headed by Dr. David A. Boyd, is designed to build up teaching and research in that field and to teach residents in psychiatry under an arrangement with the United States Veterans Administration. The new state psychiatric hospital, authorized by the last legislature, will be built at the University Medical Center and its facilities will be used for instruction and research by the medical school. All of the new appointees are graduates of the Indiana University School of Medicine.

Deaths

Harry E. Dees, M.D., of Bicknell, died on July twenty-eighth, at the Veterans' Hospital, in Indianapolis. He was sixty-four years of age. Doctor Dees graduated from Barnes Medical College, of St. Louis, Missouri, in 1908.

Fred H. Batman, M.D., of Bloomington, died on August fourth, at the age of sixty-eight. He was a graduate of Rush Medical College, in Chicago, in 1904, and he had practiced in Bloomington for more than forty years. Doctor Batman was a member of the Monroe County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

George B. Hunt, M.D., of Richmond, died on July twenty-third, at the age of sixty-four. He was a veteran of World War I, having served overseas for fourteen months, and had served as Richmond's city health officer for many years. Doctor Hunt graduated from Indiana University School of Medicine, in 1910, and he was a member of Wayne-Union County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Rufus W. Terhune, M.D., of Martinsville, died on July twenty-eighth, after an illness of several months. He was seventy-eight years of age. He graduated from the Kentucky School of Medicine, in Louisville, Kentucky, in 1891. He was an Honorary member of the Morgan County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Edward I. Wooden, M.D., of Rushville, died on August sixth, in Indianapolis, after an illness of several months. He was eighty years of age, and had retired in 1941. Doctor Wooden graduated from the Medical College of Indianapolis, in 1888, and had practiced in Rushville for fifty-three years. He had served as Rush County health officer for twenty-five consecutive years, and was secretary of the City Board of Health there for fifteen years, and as coroner for two terms. He was an honorary member of the Rush County Medical Society and the Indiana State Medical Association, and a member of the American Medical Association.

Harry Knott, M.D., of Plymouth, died at his home on August ninth, following a year's illness. He was sixty-two years of age. Doctor Knott was a graduate of the University of Illinois College of Medicine, in Chicago, in the class of 1912, and began practicing in Plymouth in 1913. He remained there until 1917, when he entered the Army as a first lieutenant. He later advanced to the rank of major and was sent overseas as commanding officer of Field Hospital 22, Sanitary Train, Seventh Division. Upon his return to Plymouth, Doctor Knott resumed the general practice of medicine, later becoming interested in radiology and anesthesia. Doctor Knott was a member of the American Society of Anesthetists, Incorporated; the Radiological Society of North America, Incorporated; the Marshall County Medical Society and the Indiana State Medical Association; and was a Fellow of the American Medical Association.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

THE COUNCIL

July 21, 1946

The Council of the Indiana State Medical Association convened for its summer meeting at 10:40 A.M., daylight savings time, Sunday, July 21, 1946, in the Columbia Club, at Indianapolis, with Dr. A. M. Mitchell, of Terre Haute, chairman, presiding. Roll call showed the following present:

Members of the Council:

First District ----------I. C. Barclay, Evansville
Second District ----------Not represented
Third District ----------A. P. Hauss, New Albany
Fourth District ----------Not represented
Fifth District ----------A. M. Mitchell, Terre Haute
Sixth District ----------W. U. Kennedy, New Castle
Seventh District ----------C. J. Clark, Indianapolis
Eighth District ----------E. H. Clauser, Muncie
Ninth District --------Wemple Dodds, Crawfordsville
Tenth District ----------Not represented
Eleventh District ----------C. S. Black, Warren
Twelfth District ----------Not represented
Thirteenth District --------Alfred Ellison, South Bend

Officers:

J. E. Ferrell, Fortville, president.
F. T. Romberger, Lafayette, president-elect.
A. F. Weyerbacher, Indianapolis, treasurer.
E. M. Shanklin, Hammond, editor of THE JOURNAL.
C. A. Nafe, Indianapolis, chairman, Executive Committee.
C. H. McCaskey, Indianapolis, member, Executive Committee.
Albert Stump, Indianapolis, attorney.
Ray E. Smith, Indianapolis, executive secretary.

Delegate to A.M.A.:

H. G. Hamer, Indianapolis.

Guests:

C. F. Thompson, Indianapolis, chairman, Veterans Fee Schedule Committee.
Leroy E. Burney, Indianapolis, State Health Commissioner.
George M. Brother, Indianapolis, Director, Bureau of Preventable Diseases, Indiana State Board of Health.

Upon motion of Dr. Hauss, seconded by Dr. Ellison, the minutes of the Council meeting held in Indianapolis on April 14, 1946, were approved as printed in the June, 1946, issue of THE JOURNAL.

REPORTS OF COUNCILORS BY DISTRICTS

Brief, informal reports by the councilors on their district meetings and activities indicated that all of the district societies are functioning and are in good condition. In addition, the following remarks were made:

DOCTOR HAUSS: The hospital situation in the Third District is getting very critical, the same as it is every place in the cities throughout Indiana. I feel that definitely the Indiana State Medical Association should try to do something about it. I believe that you men will agree with me that you are having the same trouble in your districts. Hospitals are undermanned, so far as nurses and personnel are concerned; in fact, in New Albany, at our only hospital, supplying several counties, Sister Superior recommended to the Mother House of that institution that it be closed on account of the inability to secure proper help and nursing facilities. This is a problem throughout the United States and I believe that the medical profession, more than the hospital association, should begin planning and finding ways and means of remedying the situation. It is a thing that is going to require study, and I think the sooner the Indiana State Medical Association takes the lead in this movement, the better.

DOCTOR MITCHELL: The Union Hospital has a half million dollars in cash to build an addition, and want to get priorities for it, but as far as they could go was to build the laundry, and that was all; nothing for taking care of people. So you get your friend across the river to give you priorities and you can get something done on the hospital.

DOCTOR HAUSS: It isn't a question of the buildings. We would build another hospital right now, if that would help. Salem is planning a hospital in our district. I don't know how they are going to get nurses.

DOCTOR FERRELL: Right along that line, I think the Indiana State Medical Association is taking this into consideration, especially the nursing situation. I happened to be on a program a couple of weeks ago, with Sister Andrea at St. Vincent's Hospital, and Miss Teal, in regard to trying to get young women to take up nurses' training. There are a lot of things to be taken into consideration on that, and I think it is a program well worth the effort, because many girls are going into factories and making money, and they can't see going into nurses' training. They go into business instead of entering nurses' training. Nevertheless, we are trying to work on that.

DOCTOR CLAUSER: I could complain a long time about the subject of which Doctor Hauss spoke. I think the medical society should take some action in remedying this condition. I think the hospital association, from the top down, is about three or four steps behind public opinion and public demands, and I am much interested. If we take any action I would like to be an active member on such a committee. We don't have time to discuss the whole subject at this time, but it is vitally important and something must be done. We should take active steps in correcting the situation.

DOCTOR BLACK: Doctor Lavengood, who is secretary of the Grant County Medical Society, said they had been making every effort to re-establish a nursing school at Marion General Hospital and could get no consideration from the board who approves it; said they had available material for nurses' training, and he asked me to bring it up and ask the state association to help them in any way possible to get that grant for a nurses' training school.

DOCTOR MITCHELL: Do you want to make a motion of some kind as to what the association should do?

DOCTOR HAUSS: All these things may come under the same head, but I think it is urgent enough for a special committee to be appointed to investigate and provide ways and means for promoting nurses' training and other hospital aids in the hospital. I move that this committee be appointed. (Motion seconded by Dr. Ellison; four "Ayes" two "Noes".)

DOCTOR ELLISON: I feel that this nursing problem is an extremely acute thing. For example, in South Bend we have a waiting list constantly, in the one hospital I am familiar with, of about one hundred people trying to get in. When they do get in they get mediocre care, because of the lack of nurses, and the fact that the care is so poor forestalls building any additional beds at this time. We can't take care of the patients we have. The condition is getting worse instead of improving. Many factors are involved. Most of the nurses who came out of the Army have been altered in their thinking, to the point they haven't come back to the hospital; they have gone into other fields of endeavor. Young women are not coming into training schools and there will have to be a program of propaganda initiated to change this trend, and I think a special committee is very important to have functioning on this matter.

DOCTOR MITCHELL: Doctors Clark, Ellison and Hauss will be the special committee. (At Dr. Black's suggestion, Dr. Clauser was included, and Dr. Mitchell said Dr. Clark would be chairman.)

REPORTS OF OFFICERS

Doctors Ferrell and Romberger stated they had no formal reports to make.

DOCTOR WEYERBACHER: This week our Auditing Committee went over the finances of the Indiana State Medical Association, and pronounced them O.K., approved all of our moves. There is nothing of importance to be brought before you, except some of our treasury bonds will mature in 1946. It is our intention to reinvest in treasury bonds. We finished the year last year with about a thousand dollars to the good. That is a pretty narrow margin. We will probably do a little better this year. I am sorry Doctor Ellison's enthusiasm knocked off that $5.00 assessment. We could have used it a little longer, but with our convention here this year, and our space sold, we will probably do very well. Our average holdings for general fund and medical defense fund pays us a low rate of interest, much lower than it used to be. However, the average for both funds runs 3.03, which is not too bad.

DOCTOR SHANKLIN: Your managing editor, Ray Smith, Doctor Forster, and I have had our heads together a good bit the last few months, and we believe we can promise that something new will be added to THE JOURNAL before the year is out. The executive secretary will furnish from two to three pages each month on what goes on in Indiana. That will be made up of comments on what he sees as he travels about over the state, and in his correspondence with the members of the different societies and members thereof throughout the state. Doctor Forster will prepare each month a resumé of national medical news, taken from some of the state medical journals, but principally from the county society bulletins, some of which are rather pretentious publications.

I have another pet project which I have submitted to the associates, and they are agreeable to it. The Wisconsin State Medical Association each year gets out what they call a "Blue Book." It carries, in addition to the roster of members, a copy of the medical law, a list of the officers of the medical boards, the board of pharmacy, the dental board, the veterinary board, etc., together with a wealth of other worth-while news relative to what goes on officially in Wisconsin. We thought we might do that at the end of the year, but we won't get around to it, because it will take a lot of time to get it ready, but we do hope to have an annual number, called the "Year Book," in which will be a complete roster of the members of the association, both alphabetically and by county, and in the larger communities with the street address of the members. We will have the medical law, and all of the various state boards that pertain to medicine, and other items of interest, and it will be a magazine that the members can keep on their desks the year around.

DOCTOR CLARK: I would like to suggest that you add a list of the names and telephone numbers of the legislators, both state and national.

DOCTOR SHANKLIN: That won't be too much; we can stick that in somewhere.

I have another pet project: I believe that THE JOURNAL should have a platform, just like a metropolitan paper has. Ray and I got our heads together, and this is the tentative platform, to be carried as a masthead on the editorial page: (1) Preserve American Medicine. (2) Full-time county health officers. (3) Preservation of our natural waters. (4) Maintain the present high standard of our medical center. (5) Elimination of diphtheria, and possibly smallpox, through compulsory vaccination. (6) A state-wide campaign against undulant fever. To a lot of you sitting here the latter might not mean anything, but it is getting to be a bigger problem, not only in this state, but all over the country, and it can be eliminated

through the cooperation of the state veterinary department. Lastly, the enactment of the medical registration law. These are tentative, and the platform in full will be submitted at the next meeting.

DOCTOR CLARK: I would like to suggest that the thing be headed up by the statement that we stand for the best of medical care for the public.

DOCTOR SHANKLIN: That will be all right. Those are all tentative things, but the first features will go through before we have our next meeting.

EXECUTIVE COMMITTEE MATTERS

DOCTOR NAFE: There are three things that the Executive Committee wished to refer to the Council. First, the Executive Committee last night moved that we write a letter to Doctor Gatch, expressing to him the appreciation of the Committee for the fine cooperation which has existed between the State Medical Association and the Medical School. It was suggested that the Council might want to take similar action in writing such a letter.

DOCTOR CLARK: I move that the Council take similar action. (Motion seconded by Dr. Black, and carried.)

DOCTOR NAFE: The second thing was that Dr. Carlo, chairman of the American Academy of Pediatrics, sent a request to the Executive Committee, and in his absence, Dr. Stoeffler, acting as secretary of that committee, and who is also a full-time pediatrician consultant to the Maternal and Child Welfare Division of the State Board of Health, appeared before the committee in behalf of a project sponsored nationally by the Academy of Pediatrics. This is to be a survey of the child health services in the United States. To acquaint you with this project I will read an editorial in the A.M.A. Journal of March 4, 1946. (Editorial read.)

They will send a questionnaire to every doctor and dentist, in trying to compile this thing. This has been approved by forty-one of the forty-eight states. Indiana has not approved it. It was never presented to any group, the Executive Committee or anyone else, until last night. We thought it should be considered by a larger group and are presenting it to you. The Executive Committee took no action, but my own personal feeling is that since this is sponsored by the American Academy of Pediatrics and forty-one states have approved it, certainly we would not be in a very good position if we disapprove it. The question came up last night as to whether it should be referred to the House of Delegates. Doctor Stoeffler said they are a little behind now and would like to start work on the project before the first of November. I am presenting this to you for whatever you wish to do with it.

DOCTOR CLARK: I would like to ask a question. Will the Pediatrics Academy be backed up by general practitioners in this work?

DOCTOR NAFE: I don't know. This is only a survey. A questionnaire will be sent to every doctor; first, about the facilities available for the care of children; second, what other facilities are needed, with a view of getting a factual study of the facts. In other words, he called attention to this fact: that we are now about to construct another children's hospital in the northern part of Indiana. There are no factual data to support or deny the need for a thing like that. This is a factual report to be summarized by the American Academy of Pediatrics by their officers.

DOCTOR CLARK: I move we go along with that sort of a program. I think we need that in many fields. (Motion seconded by Doctor Hauss, and carried.)

DOCTOR NAFE: We can inform him that the Council has taken that action.

There is another thing for me to bring to your attention. At the last meeting of the Executive Committee, previous to last night, the Executive Committee, at the suggestion of the Scientific Work Committee, approved of the discontinuance of the charge of $1.00 for instructional courses at the state meeting. We have received a letter from Doctor Batman, chairman of the Committee on Convention Arrangements, who has conducted these courses before, and he and the other members of his committee gave about five good reasons why it was absolutely impractical to conduct these courses without making that charge, and he requested that it be replaced. Therefore the Executive Committee went on record as rescinding its previous action, and continuing the charge of $1.00. I think before the Council takes any stand on this they probably should have read to them Doctor Batman's letter of explanation, which influenced us to make that decision.

(At this point Mr. Smith read the letter from Doctor Batman.)

DOCTOR CLARK: I move that we continue the fee for instructional courses. (Seconded by Doctor Black; motion carried.)

PLAN FOR MEDICAL CARE OF VETERANS

Dr. Charles F. Thompson, chairman of the Veterans' Fee Schedule Committee, reported on the revised agreement with the Veterans' Administration for medical care to veterans, which was accepted by the Council upon the motion of Dr. Clark, seconded by Dr. Black. Under such an agreement the state association would be obligated to the following:

(1) To request members of the state association to voluntary participation in the plan to render care to veterans in the state of Indiana.

(2) To submit to the Veterans Administration a list of the members of the State Medical Association who agree to participate in such a program.

(3) To assist the Veterans' Administration in establishing a list of competent specialists in the various counties and districts throughout the state.

(4) To appoint a Board of Review consisting of members of the state association, whose duties would be:

a. To act in an advisory capacity to the Veterans' Administration with regard to problems in

the care of veterans and the improvement of their medical care.

b. To review reports in findings which are returned as inadequate by the Veterans' Administration.

c. To make recommendations with regard to the disqualification of any members of the state association whose services are considered inadequate by the Veterans' Administration.

1946 (97TH) ANNUAL SESSION AT INDIANAPOLIS

DOCTOR MITCHELL: Doctor Batman reports that he has obtained speakers for the general session and things are going along nicely.

MEMBERSHIP PROBLEMS

(1) *Merger of Owen and Monroe County societies into the Owen-Monroe Medical Society.* Mr. Smith announced that this merger had been completed.

(2) *Merger of Brown County with Bartholomew County Medical Society.* Dr. Mitchell reported that in a telephone conversation Dr. Overpeck reported that he had talked with the Bartholomew County Medical Society and with the two physicians in Brown County. "One doctor in Brown County already belongs to the Barthlomew County Society, and the other doctor goes over there all the time, and if the Council will sanction it, it is agreeable with them for the Brown County physicians to be taken in as members of the Bartholomew County Medical Society, and have the society known as the Bartholomew-Brown County Medical Society." (Dr. Ellison moved that the Council recommend the adoption of this plan. Motion seconded by Dr. Clauser, and carried.)

(3) *Membership signs.* Two signs, suitable for hanging in physicians' offices, submitted by two different companies for approval, one selling for about $25.00 and the other for thirty-eight cents, were examined by the members of the Council. After considerable discussion, motion was made by Doctor Clark that the manufacturers of these signs be allowed to advertise them in THE JOURNAL but that the sales be made direct to the physicians, at their own expense. (This motion was seconded by Dr. Black, and carried.)

LEGISLATIVE MATTERS

Dr. Mitchell announced that the $2.00 annual registration bill is being prepared by the Legislative Committee with the assistance of Mr. Stump.

RURAL MEDICAL CARE

MR. SMITH: August first is the date set for the Conference on Rural Medical Care at Purdue. The Committee on Rural Medical Care of your Association is working with the State Board of Health and a committee from the Indiana Farm Bureau in arranging this one-day conference.

NEW BUSINESS

1. *Nominations for Editorial Board.* Dr. Clauser nominated Dr. Lall Montgomery of Muncie. This nomination was seconded by Dr. Clark, and carried. (Dr. Pierce MacKenzie, Evansville, was nominated at the January 13, 1946, meeting of the Council.)

2. *Employment of stenotypist to report Council meetings.* After considerable discussion, it was decided to dispense with detailed reports of Council meetings.

STATE FAIR EXHIBIT

The chairman introduced Dr. Robert H. Wiseheart of Lebanon, chairman of the Committee on State Fair, who reported on plans being made by his committee for the Association's health exhibit at the Indiana State Fair.

DOCTOR HAUSS: I would like to say one thing in regard to the State Fair. I think Indiana has a wonderful State Fair, but as far back as I can remember it has been marred by a lot of medical fakers, who have exhibits to sell patent medicines of all kinds. They have elaborate charts; they wear white coats; they pose as the "great doctor," unlicensed, etc.; they are given the privilege by the state organization, the State Fairgrounds Association, to sell these nostrums. I would like to make a motion right now that the Council of the Indiana State Medical Association request the Governor and the management of the State Fair not to issue a concession for patent medicine or medical treatment. (Motion seconded by Doctor Ellison, and carried.)

A.M.A. ANNUAL SESSION

DOCTOR HAMER: I am sure Doctor McCaskey, and the Chairman, and others who may have attended the San Francisco meeting, will agree that this was an important meeting of the A.M.A. Doubtless some of you have read the preliminary report of the meeting in THE JOURNAL of July 13:

"The attendance, which exceeded 7,500, the magnificent weather, which provided a week of consecutive brilliant sunshine and favorable atmosphere, the elaborate festivities arranged and conducted by representatives of the California Medical Association, the great significance of actions taken by the House of Delegates, and the perfection of the scientific programs combined to make a successful session beyond anything that was anticipated.

"The decision of the Board of Trustees to perfect the machinery of the American Medical Association for education of the American people in the accomplishments of American Medicine in the fundamentals of the National Health Program of the American Medical Association and in the advantages of a voluntary prepayment system for medical care signify the sincerity with which the Association is undertaking its responsibility to provide a high quality of medical care for all the American people. In the course of the deliberations of the House of Delegates misunderstandings as

to the specific functions allotted to the Council on Medical Service and some of the other activities of the bureaus and agencies of the American Medical Association were clarified.

"American physicians may look forward to complete cooperation on the part of the organization with their plans for making the one hundredth anniversary session of the American Medical Association, to be held in Atlantic City in June, 1947, the greatest medical assemblage that the world has yet known."

Action of the House of Delegates was taken on many important resolutions and I shall call attention to a few of the outstanding things that were accomplished.

It was decided that a supplemental session of the House of Delegates should be held once during the interval between annual sessions. The first of such meetings will take place this coming December in Chicago. It will be a satisfaction to our Chairman, I am sure, to note that a Speakers' Bureau is in the process of establishment. It is he who was responsible for that suggestion.

The Board of Trustees is planning such a bureau with "briefing" to be completed at A.M.A. headquarters. Compulsory health insurance and other problems and programs are to be included.

The action on reapportionment of delegates (one delegate to each one thousand members) will amount to very little change. As the Philippine Islands become an independent republic, two members are removed from the House. The addition of a delegate from the new Section on General Practice, the gain of one each for California, Oregon, North Carolina and the District of Columbia, and the loss of one for Mississippi, Ohio and Pennsylvania, will keep the membership at 175, as heretofore.

A resolution was approved recommending that county societies build up their membership and urge members to make application for Fellowship. Approximately sixty thousand doctors in the United States are not affiliated with their local society, and many of these no doubt are eligible.

While some such action has been taken before, it was again proposed that all resolutions be sent to THE JOURNAL for publication thirty days before the annual meeting, in order that all of the delegates might be familiar with these matters before the meeting.

The House approved the establishment of the Section on General Practice of Medicine.

A rather important resolution was proposed concerning the International Public Health Commission, or Committee.

A resolution was adopted, recommending to Doctor Parran, chairman of the American delegation to the International Health Conference, that they restrict their activities to the questions of communicable diseases and public health, and not get involved in a discussion of the type or control of medical service rendered in the member nations.

Numerous other resolutions were approved, about which you may read in the Proceedings of the House of Delegates, published in THE JOURNAL. Perhaps you are more interested in the discussions and the actions with reference to the reorganization of the A.M.A. headquarters. . . . The resolution proposed by California was read by title: "A Resolution Concerning the Activities of the Editor of the A.M.A. Journal." Action on the resolution was deferred. . . . We have a right to be proud that Doctor Sensenich, chairman of the Board of Trustees, has had much to do in initiating this reorganization of the Chicago office. Leading up to the reorganization, the Board of Trustees had Raymond Rich and Company, public relations experts, make a survey of the A.M.A. and recommendations for future conduct. The recommendations made by this organization are as follows:

(1) To take a more active part in dramatizing and making known to the public scientific advances in medicine.

(2) To employ a top-flight economist to study and make recommendations on the over-all picture of medical economics.

(3) To employ the best public relations man obtainable, to assist the general manager.

Adoption of the recommendation was voted unanimously. Immediately upon the passage of this resolution, California withdrew its resolution.

In this action the Council on Medical Service and Public Relations will no longer carry the latter part of the title, but will be known as the Council on Medical Service. Matters pertaining to public relations will be carried on in the headquarters office, under the assistant to the general manager.

MUTUAL MEDICAL INSURANCE, INC.

DOCTOR KENNEDY: We have achieved our goal in the collection of funds. We have a balance of $82,040. Everything else is set. Stationery and advertising matter are going through the press. We are waiting only for the Blue Cross to sell the $25,000 paid-up policies that the State Insurance Department requires before we can validate our insurance. The Blue Cross, with its rather limited number of solicitors, is attacking the problem by going first to the larger companies of the state, where we may hope to get larger enrollments in a short time. The plan of putting up these enrollments are rather complicated things. First of all, you have to sell it to the general management; then to the local factories, and then within the factories, to the foremen, and, by advertising, to the employees. All that is preliminary to the actual enrollment.

So far, we have contacted General Motors. My information is that they are going all out, to accompany the Blue Cross people and put their whole weight behind it. We hope to achieve something like the Blue Cross did in Anderson recently. They set up a community group, and now Anderson has 65 per cent of its entire population cov-

ered by the Blue Cross plan. We will have to do something of the sort in order to meet the needs that seem to be in sight, but first of all we have to take care of these industrial groups, and then we can go out to the communities.

I find, in my own office, repeated inquiries from people who are not employed in industry, as to when these plans will be available to them. I think in my own community, we will put on a campaign, use a bank as the point of collection, a plan used in Missouri with great satisfaction, and when we get the actual thing rolling, these community plans should quickly make us the third largest organization in the country.

The ones that have already signed up with us, the general managements, are:

General Motors Corporation (all divisions).
Chrysler Corporation (Evansville, New Castle, Kokomo).
Aluminum Company of America (Lafayette).
Indiana Bell Telephone Company (entire state).
Lever Brothers (Whiting).
William H. Block Company (Indianapolis).

The other companies, who have stated their intention of enrolling, although no formal contracts have been signed, are:

Peerless Wire Company (Lafayette).
Rostone Corporation (Lafayette).
Fairfield Manufacturing Company (Lafayette).
Seegar-Sunbeam Company (Evansville).
Iglehart Brothers (General Foods) Evansville.
Kraft Cheese Company (state wide).
Alton Box Board Company (Lafayette).
M. Blumberg Company (Terre Haute).
American National Bank (Indianapolis).
Prestolite Company (Indianapolis).
Lake County Department of Welfare (Gary).
Indiana Limestone (Bedford).

In addition to these groups with personnel aggregating more than fifty thousand, many small groups have asked to start enrollment as quickly as we can get to them. We are now devoting the entire time of our Enrollment Department to the enrollment of Blue Cross groups in the Doctors' Plan.

MR. STUMP: I had a talk with Mr. Spring yesterday. They are in the actual business of enrolling employees with General Motors. After the enrollment there are some further processes. All of these payments are collected in advance by deduction from their wage checks, so that enrollment made this month will have to be deducted at the middle or the end of the month, or, if later, they would have to go into August. It is our hope that by the time the State Association meets we will be able to report a large membership. We have gone, with the Blue Cross, into new offices in the Test Building, the expense of which is pro-rated. We are keeping our expenses down as low as we can. Until our claims begin coming in, we can control this. Before the state meeting we hope to have a complete, up-to-date report available to all who are interested, so they can see exactly what has been done, and what the results and the prospects are at that time.

STATE TUBERCULOSIS PROGRAM

DOCTOR BURNEY: I wonder if I might digress for just a minute. About a year ago I appeared here, my first appearance as State Health Commissioner of Indiana. I would like to express my sincere appreciation of the assistance and support and continued confidence that organized medicine has given to the State Board of Health. I hope that in the succeeding years we may continue to have your assistance and support, and merit your confidence. We have received, too, splendid cooperation from THE JOURNAL. Several editorials have appeared which helped us a great deal in promoting better public health programs.

We would like to present for your suggestions an outline of the proposed tuberculosis control program of the State Board of Health. We have discussed this with individual members of the Indiana Roentgenological Association. After getting their assistance, it was presented before the entire Roentgenological Association. Although they took no formal action, it was my understanding that they endorsed the program. We now want to present it to the Council for your comments and suggestions.

First, I would like to read to you a general outline of the general objectives, as approved by our Board of Health.

"It is moved:

"That the State Board of Health intensify efforts in the control and eradication of tuberculosis in Indiana by the utilization of all available methods and facilities which have been proved to be effective and scientifically and professionally sound;

"That the staff in charge of the conduct of this program be instructed to seek the guidance and support of all professional groups who are by the nature of their training qualified to assist in the technical and professional details, and other groups who are in a position to offer valuable assistance in the public relations aspects of the developing program; and, finally,

"That this body declare its intentions and objectives in regard to tuberculosis control to be a program to safeguard the citizens of the state against tuberculosis through the following activities:

1. Education—Continuation of educational efforts through lectures, movies, posters, pamphlets, radio, etc., to enlighten the public on the cause, mode of transmission, need for early diagnosis, isolation and treatment, and related facts;

2. Promotion of Early Diagnosis by Mass X-ray Screening of the Public—To make available to as many of the public as possible, a chest x-ray using the 35 mm. or 70 mm. photofluoroscopic technique (this should not be misconstrued as diagnostic chest x-ray, but purely a means of screening out those who should have

further check-up and diagnosis through their private physician);

3. Promotion of Better Case Reporting of Tuberculosis and the Effective Utilization of this Information;

4. Consultatory Service to the Tuberculosis Hospitals throughout the State, and to all professional and lay groups participating in tuberculosis control;

5. Study and promotion of needed legislation. (Above resolution passed by the Indiana State Board of Health on March 14, 1946.)"

That, in general, is the idea of our Board of Health, and we have elaborated on that very briefly. I would like to read two lines from an article in the *Annals of Internal Medicine*, which I think give our position as a public health agency:

"The early diagnosis of pulmonary tuberculosis is fundamentally a clinical problem. Although the first steps in case-finding, which consist of tuberculin testing and roentgen-ray surveys, may be viewed as techniques of public health administration and roentgenology, the evaluation and management of the suspected or manifest disease found is the responsibility of the clinician."

We are primarily concerned in case finding, to see that these contagious cases are isolated. Our proposed program is detailed in the following paragraphs:

"First, to acquire photofluoroscopic equipment."

We have two of those units already delivered. They are 70 mm. photofluoroscopic units. One unit we are purchasing in collaboration with the Tuberculosis Association, a mobile unit, and one we are buying ourselves.

"Second, to employ technicians.

"Third, to make available the technical service of mass radiography to all sections of the state and the public at large on a county basis, contingent upon the manifest interest and desire of the local organized medical group and the local health department, and contingent upon the availability of local means for the professional services required to read films by a qualified radiologist or chest physician. Initial efforts will be directed at easily-accessible segments of population, such as high schools, industries, and other groups. It is suggested that where the funds of local tuberculosis societies are available that this would be a sound investment of their funds. In other counties it might be desirable for the local health department to afford these funds."

By that we refer to an honorarium given to a member of the Roentgenological Association or a recognized specialist in chest diseases for the interpretation of the screening films.

"To make available both the technical and professional services required for the surveys in all state institutions.

"To cooperate with local professional groups and local volunteer health agencies in promoting and organizing mass survey programs and projects.

"Promotion of Better Case Reporting of Tuberculosis and the Effective Utilization of this Information.

"(a) Direct appeal to medical societies and their members.

"(b) Tapping of all other sources of information such as general and tuberculosis hospitals, as the results of physical examinations of school teachers, janitors, and bus drivers, etc.

"(c) Machine tabulation of accumulated data.

"(d) Extension of records and evaluation methods.

"Finally, Consultatory Service to the Tuberculosis Hospitals Throughout the State, and to all Professional Lay Groups Participating in Tuberculosis Control.

"(a) Furnish postmortem and pathologic services.

"(b) Render direct consultation service when requested.

"(c) Use of the Sanatorium Consultation Committee."

The Indiana Roentgenological Association appointed their Executive Committee to work with us on any problems that we have with which they might be of assistance, such as the selection of the proper kind of machines, the policies with reference to the reading of films, etc.

Briefly we propose this procedure for mass screening surveys. If a request comes to us from a local Tuberculosis Association, we will refer it back to the local health officer. If the local health officer requests us to come in, and if that request is accompanied by an endorsement, or a request from the local medical society, we will agree to assist in the local program. If the local medical society or the local health officer does not endorse the request, we will have to refuse the request. We will not participate at the request of any local group unless we have the endorsement or the request of both the local health officer and the local medical society.

In this program, I believe it should be re-emphasized that it is a screening process. We will have a standard card that will be made out on all the people. They must submit the name of their family physician when this screening test is made. Negative reports will be sent direct to them. If John Jones comes in and his film is negative, we will send him a letter stating that his screening x-ray was negative. If it was doubtful or positive, the report will be sent to the family physician, and a letter will be sent to the patient, stating that there was some question about his case, and suggesting that he go to his physician, to whom we have sent a copy of the report. Workers in industry will be handled in the same manner.

I would like to have Doctor Brother read a paragraph which we believe will be desirable to give to the public. It is prepared by the American Roentgenological Association. We are afraid that the public may get the erroneous idea that this is an

(Continued on page xxx.)

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(Continued from page 476.)

x-ray examination. It is purely a screening process, and not a diagnostic procedure, and must be followed up, in questionable cases, by history, physical and x-ray examinations, and other tests deemed necessary by the family physician.

Doctor Brother is director of the Bureau of Preventable Diseases of the Indiana State Board of Health.

DOCTOR BROTHER: If I may, I would like to elaborate on two points; first, as I understand this, the State Health Department is only affording the technical service for the taking of these films, and that a professional interpretation is done by the chest men, or roentgenologists, which service is made available through local facilities; and the second point is, that although this mass work is thought to be recent, within the last five years there has been a good bit of it going on in Indiana, in the larger cities, such as Indianapolis, Terre Haute, Evansville, and Fort Wayne; they have had this work done. This is largely to meet the need for making such a service available to the more rural parts of the state, particularly where they have not been able to afford that before.

The suggested statement to go on the card that each patient receives will be as follows:

"The survey examination of the chest which you are receiving is a screening procedure for the detection of active pulmonary tuberculosis. It should not be confused with a complete examination of the chest by a clinical radiologist, which procedure requires considerable time and usually several roentgenograms. The x-ray film made of your chest in this routine procedure will be interpreted by a specially trained physician. If the survey film of your chest reveals any indication of disease, you will be so advised, and a report will be given to your physician. You should then promptly consult your physician for a complete examination."

DOCTOR BURNEY: Thank you, Doctor Brother. There is one other point I want to emphasize. We are finding, in our sanitariums, that only about 15 per cent of the admissions are early cases; the other 85 per cent are moderately or far-advanced cases. We hope, through this mass screening, to raise that 15 per cent minimal cases, finding our cases earlier so that they will have a better chance to obtain a cure, and also secure isolation before they have infected other members of their families.

DOCTOR DODDS: There was a request sent in from the Montgomery County Tuberculosis Association for screening the industries there. Does that go to the State Board of Health, or does it go to the State Tuberculosis Association?

DOCTOR BURNEY: The mobile unit we have bought, purchased jointly with the Tuberculosis Association, will be staffed by our employees. It will operate in the same manner as our other units.

DOCTOR ELLISON: You expect to find more active cases. Do you have beds available for these people?

DOCTOR BURNEY: I think we probably have beds in many of the institutions which are not used because of lack of personnel and other conditions. Michigan has been performing mass screening for several years. They state that even though they are finding a great number of minimal cases, it is not increasing the number of sanitarium patients. I suppose they mean that they are finding early cases which can be treated on an ambulatory basis.

DOCTOR HAUSS: I would like to clarify a few points on this. Definitely I am very much in sympathy with closer cooperation with the State Board of Health. I do want to take issue with Doctor Burney and the State Board of Health on some of the transactions going on thus far.

Down in Floyd County and Clarke County we are definitely in favor of a full-time health officer. The Floyd County Medical Society has gone on record endorsing it, yet the representatives of the State Board of Health have been before the Rotary Club, and everybody except the Floyd County Medical Society.

I do feel that instead of these things being first cleared with the county health officer, and the tuberculosis society or the Rotary Club, they should be cleared first with the county medical society. I believe we can get better cooperation and work better together if we get together right at the start, instead of calling the medical society in third, fourth, or fifth. These things are coming up more and more in the counties and state, and nationally, and I feel that we should work more together.

I happen to be on the Advisory Council of the Indiana State Board of Health. We had an organization meeting; we had our pictures taken, and that is the last that ever happened. So far as the committee having any advisory capacity, we haven't had any at all. I don't believe that this is the fault of Doctor Burney, nor is it a criticism of the State Board. This is an appeal that we get together closer and work more together; exchange ideas, and keep the thing in the medical profession, and not in the lay groups.

DOCTOR MITCHELL: Any action you want to take on this? By consent, it continues as it has in the past.

There are one or two things yet to come up. I think every one of the Councilors should study the minutes of the House of Delegates of the A.M.A. There is particular reference in there to this bituminous coal thing. At the present time they have $6,000,000 or $7,000,000, which they are going to set up as health facilities, doctors, health centers, and doctors in various communities, and since this is a coal state, in the southern and western parts, there is going to be some involvement of doctors within this health program of some sort. What it is going to be, I don't know. This fund is to be handled by John Lewis and somebody appointed by the operators, and someone appointed by the two of them. In some states it will have no bearing, but I think it should be watched, and keep your

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fingers on it, so that by the time we meet again, if something has happened in the meantime, if they start to establish various diagnostic clinics by the coal miners, we should be on our toes in protecting the doctors in the community in any way possible, so that they will maintain their individuality. That is something you haven't thought about, but it is a thing that has a very definite bearing on the practice of medicine, and whether they will want to do it on a contract basis, or a per case basis, nobody knows. But keep your ears to the ground, so that by the next meeting we will know something about it. Study the House of Delegates report, and the resolutions, and give the whole contract between the government and the operators and the miners, and as to what the moneys and all are for. That is in the last two issues of *The Journal of the American Medical Association.*

DOCTOR BURNEY: We were thinking about setting up one of these mass screening units in our building at the State Fair. We would be glad to make this a cooperative project with the State Medical Association and the State Tuberculosis Association.

DOCTOR MITCHELL: Take it up with the State Fair Committee. Anything else? If not, we stand adjourned until further notice.

(Meeting adjourned at 2:00 P.M.)

EXECUTIVE COMMITTEE

July 20, 1946

Roll call showed the following present: C. A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; F. T. Romberger, M.D.; A. M. Mitchell, M.D.; E. M. Shanklin, M.D.; Albert Stump, attorney, and Ray E. Smith, executive secretary.

Guest: Walter Stoeffler, M.D., Pediatric Consultant to the Bureau of Maternal and Child Health of the Indiana State Board of Health.

Statements of receipts and expenditures for June for the association committees and THE JOURNAL were approved.

Membership Report

Number of members July 19, 1946	3,397*
Number of members July 19, 1945	3,275
Gain over last year	122

* Includes 831 in military service, 341 veterans and 155 honorary members.

Treasurer's Office

Report made that the Auditing Committee had met on July 17 and found the securities of the association in order.

Federal income taxes. The executive secretary reported that letter had been received from the Treasury Department at Washington stating that the association is exempt from the payment of federal income taxes.

1946 Annual Session, Indianapolis, October 29, 30, 31, 1946

Instructional courses. Upon the motion of Dr. Mitchell, seconded by Dr. Romberger, the Executive Committee rescinded the action previously taken and went on record approving the $1.00 fee to be charged for instructional courses.

Annual dinner speaker. Report made that Dr. Olin West, president-elect of the American Medical Association, had accepted invitation to speak at the annual dinner.

Insurance on exhibitors' property. On the motion of Dr. Mitchell, seconded by Dr. Romberger, the committee authorized the executive secretary to contract for risk insurance covering the contents of the exhibitors' booths during the annual session.

Liability insurance. On the motion of Dr. Mitchell, seconded by Dr. McCaskey, the executive secretary was instructed to take out public liability insurance, in $10,000 to $20,000 coverage, for the three days of the annual session.

Legislative Matters

National

Wagner-Murray-Dingell Bill. Letter received from Dr. George F. Lull, secretary and general manager of the American Medical Association, suggesting that the Indiana State Medical Association request time to be heard before the Senate Committee on Education and Labor, brought to the attention of the committee. The committee decided that a request should be made to Senator Murray, committee chairman, for such an appearance, and that if this is granted, Dr. Jacob Oliphant should be asked to appear for the Indiana State Medical Association.

Taft bill. Copy of the letter from the secretary of the Michigan State Medical Society to Senator Taft, endorsing S. 2143, was read.

EMIC bill. The secretary reported that a telegram had been received from Senator Capehart and a letter from Senator Willis to the effect that the EMIC bill was killed for this seventy-ninth session of Congress.

Prepayment Medical Care

Mutual Medical Insurance, Inc.

a. The attorney reported that employees of six companies are now being enrolled in Mutual Medical Insurance, Inc., and that the company expected to start operations with approximately 75,000 persons covered by certificates in force.

b. Letter received from a roentgenologist concerning x-ray coverage read to the committee. The attorney for Mutual Medical Insurance, Inc., reported that the company had decided to allow Blue Cross to continue offering x-ray services until Mutual Medical Service, Inc., is able to include these services in its certificate.



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Dr. McCaskey discussed the fact that the Hospital Service of California and the California Physicians' Service both were offering prepayment medical care insurance in competition one with the other, and this was resulting in considerable confusion.

Organization Matters

Indiana Board of General Practice of Medicine, Inc. The secretary reported that 63 applications had been accepted for membership in the Founders Group.

On motion of Dr. Mitchell, seconded by Dr. McCaskey, the committee voted to invite the associate editor of THE JOURNAL to attend all future Executive Committee meetings.

State Fair Committee. On motion of Dr. Mitchell, seconded by Dr. Romberger, the committee voted to appropriate $250.00 to the Committee on State Fair to cover expenses of the exhibit held during the State Fair.

Michigan State Medical Society meeting, Detroit, September 25 to 27, 1946. On the motion of Dr. Romberger, seconded by Dr. McCaskey, the executive secretary is to attend the annual session of the Michigan State Medical Society in Detroit, September 25-27, 1946.

Industrial Health Conference, Boston, September 30 to October 3, 1946. It was taken by consent that the letter received from the Council on Industrial Health of the American Medical Association concerning this conference be sent to the Committee on Industrial Health of the state association, of which Dr. E. S. Jones of Hammond is chairman.

State Board of Medical Registration and Examination

Annual Registration Law. The attorney for the association reported that he is working on this bill.

State Board of Health

Proposed survey of American Academy of Pediatrics. Dr. Walter Stoeffler, executive secretary of the American Academy of Pediatrics Child Health Study in Indiana, appeared before the executive committee and explained that the purpose of this survey is to obtain basic information on medical care available for children in each state. The matter of giving approval to the survey was referred to the Council on motion of Dr. McCaskey, seconded by Dr. Romberger.

On motion of Dr. Mitchell, seconded by Dr. Romberger, the committee voted to ask the Division of Food and Drugs of the Indiana State Board of Health to send information regarding the refilling of prescriptions to all members of the association.

A.M.A. Annual Session at San Francisco

The executive secretary reported that seventy-eight persons had taken the Indiana special train to the A.M.A. annual session at San Francisco.

The Journal

Report on advertising:

Additions	$1,570.57
Decreases	209.93
Total increase during June and July	$1,360.64

Total increase over budget estimate, 1946, $4,245.40.

Medical Defense

The chairman of the committee read the following letter received from the St. Paul Mercury Indemnity Company setting out the company's interpretation of who is an assistant to a physician in matters of writing physicians' and surgeons' individual malpractice liability:

"It has been generally understood the assistants were to be the following:

'An assistant is a physician, surgeon, dentist, anesthetist, masseur, physiotherapist, x-ray or radium technician. While a nurse, laboratory technician, x-ray technician for diagnosis only, or "office" employee is an assistant, his or her professional duties and the hazards thereof are limited and no additional charge is required.'

"A nurse performing regular nursing duties is not to be considered as an assistant for additional charge; however, if a nurse or any other person performs duties similar to a physician, surgeon, dentist, anesthetist, masseur, physiotherapist, x-ray or radium technician, then a charge must be made for such nurse or other assistant. The additional point that we wish to bring out is that in determining the assistant charge, even though the person in question may not technically have the above title, yet if they perform such duties then the added hazard is there and we should receive the additional premium charge in accordance with our plan."

Letter of Appreciation to Dr. Gatch

Dr. Nafe and Dr. McCaskey were directed to prepare a letter to be sent to Dr. W. D. Gatch, expressing the appreciation of the State Medical Association for his years of service as dean of the Indiana University School of Medicine. This motion was made by Dr. Mitchell, seconded by Dr. McCaskey.

There being no further business, the meeting was adjourned.

BUREAU OF PUBLICITY

July 15, 1946

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary:

Minutes of the meeting of June 17, 1946, were approved and signed.

The following news release for daily newspapers

was approved: Monday, July 15, 1946—"Snake Bite Is Vacation Danger."

The secretary was instructed to write the secretaries of county medical societies within whose boundaries radio stations are located and suggest to them that they get the stations to use A.M.A. recordings which may be procured without cost to the societies or the radio stations.

BUREAU OF PUBLICITY

July 29, 1946.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The following news release for daily newspapers was approved:

Monday, July 29, 1946—"Eat Foods that Help Keep You Cool."

The following releases for "Hints on Health" for weekly newspapers were approved:

Week of August 5, 1946—"Control of Rabies."
Week of August 12, 1946—"Food Poisoning."
Week of August 19, 1946—"Spastic Colitis."
Week of August 26, 1946—"Rats Are a Menace."

The secretary was authorized to order the electrical transcriptions entitled "Melody of Life" from the Bureau of Health Education, American Medical Association, for use on radio station WFBM.

Copy for a folder on "Information Regarding the Prevention of Communicable Diseases," to be issued jointly by the Indiana State Medical Association and the State Board of Health, was considered and the secretary was instructed to submit it to several pediatricians for their opinions. Approval of the bureau was given conditional upon approval of the pediatricians.

The bureau decided against distributing literature against federal legislation opposed by the medical profession at the 1946 state fair.

The secretary reported that the Woman's Auxiliary had accepted the ten suggested programs for local units for 1946-47, and that they had been mimeographed by the state headquarters' office for distribution by the Auxiliary's Program Committee.

UNITED STATES WAR SAVINGS BONDS

Three series of United States Savings Bonds are now on sale as a part of the program for financing the war. They are officially designated United States War Savings Bonds of Series E, Series F, and Series G; together they are commonly referred to as War Savings Bonds, and separately as Series E, Series F, or Series G Bonds. Bonds of Series E include bonds issued as War Savings Bonds, and those previously issued as Defense Savings Bonds. Invest now!

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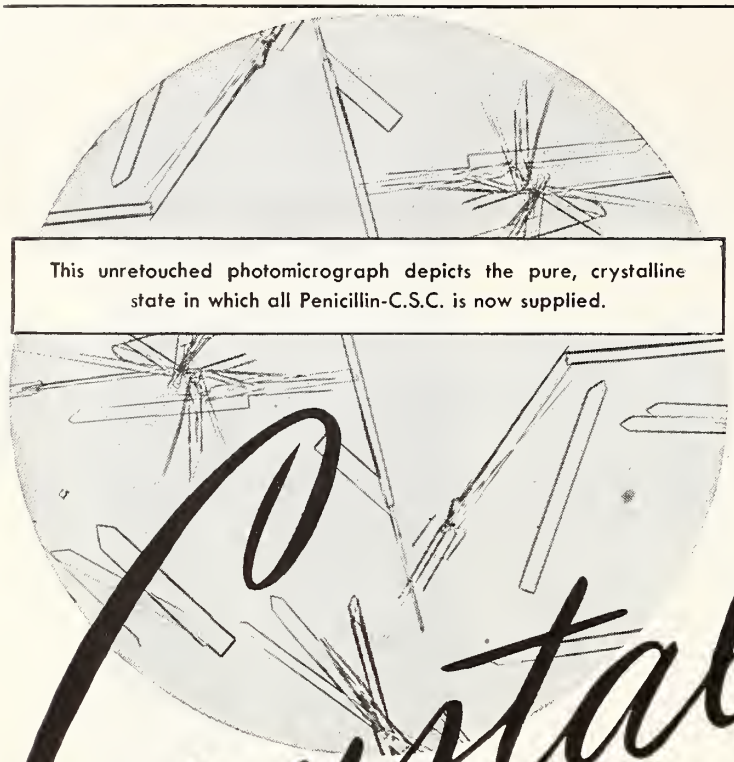
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[1] "The potency of the penicillin undoubtedly affected the results. The first 15 patients, all treated with the same batch of penicillin, were cured. The next 7 patients were treated with the same dosage of a different batch of penicillin. Five of these 7 were not cured. Assays of penicillin used for these 7 patients showed it to be of reduced potency." Trumper, M., and Thompson, G. J.: Prolonging the Effects of Penicillin by Chilling, J.A.M.A. *130*: 628 (March 9) 1946.



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CHRONIC BRUCELLOSIS AS A PUBLIC HEALTH PROBLEM

THURMAN B. RICE, M.D.*

INDIANAPOLIS

It was in 1928 that Dr. Eduard Francis, of the United States Public Health Service, speaking at the annual meeting of the Indiana State Medical Association, told us that undulant fever (brucellosis) was of more importance to the people of Indiana than typhoid fever. It seemed a rash statement then and caused considerable adverse comment. The correctness of his opinion, however, has long since been entirely proved. Now, when I say that within ten years brucellosis may well be considered the most important infectious disease in the state, it will likewise seem unreasonable. It is very probable that at the present time only three transmissible diseases cause more morbidity and pain. Syphilis, gonorrhea, and tuberculosis should probably rank above it at this time, but rapid progress is being made against all of these diseases, while we are but coming to realize the seriousness of the brucellosis problem.

HISTORY OF BRUCELLOSIS

A brief history of this intriguing infection may serve a useful purpose in refreshing the memory of the reader. Malta fever had long been the scourge of the warm countries surrounding the Mediterranean Sea. The British garrisons had been plagued by it for decades, when in 1887 David Bruce, of the British military services, isolated the organism and proved that it was transmitted by drinking the milk of infected goats. Somewhat later a Dane by the name of Bang proved that an organism, later known as Bang's bacillus, was the cause of contagious abortion in cattle. In 1917 (published in 1918) Alice Evans, of the United States Public Health Service, proved that the organism of Bruce and that of Bang were either identical or very closely related. She recommended that physicians begin to look for Malta or undulant fever here in the United States. Shortly after physicians had learned how to recognize it, it was found that there was a good deal of it. As they study the problem further, the prevalence is found to be much greater than was supposed only a few years ago.

One of the first papers published on the subject was that of Dr. A. S. Giordano (*Journal Ind. State Med. Ass'n*, 22:135-141, Apr., 1929.) One of the first definite epidemics to be described was that which occurred at Richmond, Indiana, among the students of Earlham College, who were given raw milk from a supposedly model dairy belonging to the college. We were rather quickly brought to an awareness of the really pointed fact that this germ can make people very ill. It was not long until we realized that they might remain ill for a long time. True, it did not often kill outright, but it was perfectly able to destroy efficiency, health, and the joy of living. Some of the students who had the acute attack in the Earlham epidemic were still ailing three or four years later, and may possibly be ailing to this day.

REMEDIAL MEASURES

The remedy seemed clear. We would eradicate the disease among the cattle, and until that was done we would pasteurize the milk. Well and good; both of these objectives are very worth while, and both have been carried out to such an extent as has been most useful. Neither objective has been completely attained, however. There are still many cases of acute brucellosis diagnosed each year, and a great many more that are missed. What is more significant in the present connection is the fact that there are an undetermined number of

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chronic cases in the state, and in the entire Central States area. How many cases there are it is impossible to say because the methods of diagnosis are not perfected to the point where it is possible to state with certainty just who has the disease. Some estimates have put the percentage as high as 10 per cent of the adult rural population. Be it understood that such a statement is a guess, but it does bring out the fact that the authorities making such an estimate are, indeed, taking the matter very seriously. There is no doubt that the disease also exists in the city populations, but is probably considerably less prevalent there. The solution of the problem seems a great deal further away than it did in 1930, or at any time since then.

BACTERIOLOGY OF BRUCELLOSIS

Let us go back a bit and bring up the basic bacteriology of the disease. There are three strains of the organism. 1. Brucella abortus, or the bovine strain, is the one which is responsible for contagious abortion in cattle. It causes a granulomatous infection of the udder and the uterus, the pathological picture being very much like that of tuberculosis. Usually the cow aborts, and so ends her first pregnancy after contracting such an infection. She will have difficulty in becoming pregnant again, but if she should become so, she will usually carry that and subsequent fetuses to term. The discharges from her genital tract are infectious to other cows, to the male animal which has sexual contact with her, and to human beings who may contaminate themselves with the discharges from the genital organs, or who may drink the unpasteurized milk from her infected udder. The human being may contract the acute disease which, being improperly handled, may become a chronic infection; or the individual may be found later to have the chronic form of the disease without any history of an acute attack. The bovine form of the disease is not very severe in human beings, and it is certain that it requires rather heavy contamination to transmit the disease to human beings. Authorities believe that this form of the germ never causes a real epidemic although it is doubtless responsible for some of the "endemic" cases which are occasionally seen. In past years we have been much worried about the "abortus infection" in man, and have been rather inclined to be somewhat critical of our good friend, "Bossy, the Cow." It is very probable that we were "barking up the wrong tree."

Now comes an improved understanding of the situation, which assures us that it is "Porky, the Pig" who is the unfortunate vendor of brucellosis. The swine strain (Brucella suis) is very much more infectious and also far more virulent than the bovine form. Practically all epidemics are due to this strain, or to the goat or caprine strain (Brucella melitensis), which is much like Brucella suis in its effect upon human beings. Even when the disease has been spread by cows' milk the strain found in epidemics is usually Brucella suis or Brucella melitensis, which have been transmitted to cattle and then in turn to human beings.

SOURCE OF INFECTION

It may well be asked how we can get the disease from hogs when we do not drink the milk of such animals. This question is asked only by those who have been too thoroughly impressed with the view that milk is the carrying agent. The farmer has many contacts with hogs which may be dangerous. He breathes the dust from the hog lot; he gets the mud and dirt from the hogs and the hog lot on his feet and hands; he offers dangerous obstetrical service for his sows; he lances abscesses and castrates his animals; and he butchers the animals and handles the carcasses when they are warm. It is even possible that it is dangerous to cut and handle the cold cuts of meat. All authorities agree that it is not dangerous to eat the meat of such animals if it is cooked.

The person so contaminated can suffer the acute form of the disease. As a matter of fact, a goodly number of farmers, veterinarians, and slaughterhouse operators do contract the acute form. Most of these patients make the serious mistake of refusing to seek treatment, and thus the infection runs into the chronic form, or they may seem to have the chronic infection without a definite history of an acute attack.

We have already mentioned the fact that the goat strain (Brucella melitensis) is in many respects like the swine form, and causes serious infection. It may be that our methods of differentiation of the strains has been sufficiently improved to account for the fact that the swine and goat strains seem to be more common than was formerly the case; or it may be that they actually are so. Anyway, we are coming to a realization of the fact that it is these strains which are now causing the greatest concern.

The Brucella organisms are peculiar in that they give very different symptoms in different animals. The pig is prone to have a septicemia when ill from the disease. Such an animal is dangerous to the butcher, to the veterinarian, or to the farmer who castrates such an animal or does any sort of surgery upon it. It often suffers a spondylitis as a result of a localization in the bodies of the vertebrae. Modern methods of cutting pork chops with a bandsaw become significant in such cases, because the bone dust is spread over the surface of the chop which is later handled by the meat-cutter and the housewife. Is such bone dust infectious? Well, we do not know positively, but we are certain that the germs were alive when the animal was killed, and that icebox temperature preserves the life of the organism in the bacteriological laboratory. The infected pig is very prone to an abscess of the testicle, which may make castration a dangerous operation for the veterinarian or the farmer. It also involves the genital tract of the female, making obstetrical procedures dangerous. The pig also is subject to arthritis as a result of Brucella

infection. As the carcass of the butchered animal is dismembered, it is exactly through these joints that the farmer puts his knife, and he may contaminate his hands. Oh, there are plenty of ways for the farmer to catch the infection.

In horses the Brucella infection is usually seen at one or the other end of the ligamentum nuchae, which is the ligament that holds up the horse's head. At the upper end of the ligament the infection is known as "poll-evil"; at the lower end it is called "fistula-in-withers," "fistulous withers" or just "fistula." The dressing of these lesions is a dangerous procedure and should be undertaken only when the operator is wearing intact rubber gloves and uses every other precaution to avoid infection.

PUBLIC HEALTH PROBLEM

In approaching the problem of chronic brucellosis as a public health problem it is necessary for the reader to understand that there is still very much to be learned about the subject, and also to know that as we understand the problem better it seems to become greater rather than simpler. We now believe that as much as 70 per cent of the cases, and the worst cases at that, are of swine origin, or if they come from cattle the cattle are infected with the suis or swine strain. This is a serious matter, because very little progress has been made in controlling the swine infection. Hogs are small animals and are rather difficult to catch, bleed and otherwise treat. They are not valuable enough to warrant a great deal of laboratory work or treatment. It might seem that they could be quickly killed off and other non-infected animals raised from fine herds. Unfortunately, the highly pedigreed animals, the show stock, are more likely to have the infection than the "razorbacks" for the very good reason that it is the fine herds which are taken to fairs and hog shows, and which are bought and sold across state lines from farms hundreds of miles away.

The farmer does not dread this infection in hogs as much as he does in cattle for the reason that it is not so disastrous from an economic standpoint as is the corresponding disease in cattle. However, it is more dangerous to his health, but until very recently, at least, he has not known that fact, and in many instances does not know it yet—nor will he believe it when told.

Furthermore, the diagnosis of the chronic condition is quite unsatisfactory. Blood cultures are of no value when they are negative, as they commonly are, unless the sample was taken at the height of an unusually sharp recurrence. Even then the culture is very likely to be negative. We repeat that a negative blood culture is of no value whatever in proving freedom from the disease. A positive culture is to be trusted only when the ability of the bacteriologist and the integrity and judgment of the laboratory are beyond question. Agglutination tests are likewise to be regarded with suspicion. The chronic case will have a titre that is low and might easily show no significant agglutination. If the blood specimen has been taken during an acute recurrence it will likely be higher, but might, indeed, be elevated—anamnestic reaction—on the occasion when the patient had an elevated temperature for any reason whatever entirely aside from his possible brucellosis infection. Persons who have had the disease or who have received brucellosis vaccine might give such a reaction at a time when they were quite free from brucellosis infection. The skin reaction likewise leaves much to be desired as a diagnostic test. In the first place the test is by no means well standardized. A preparation made by Huddleston, brucellergin, brucellin, the vaccine intended for treatment but in this instance used intradermally, and other products have been used in making skin tests. When a red spot is left at the site of injection the test is interpreted as a positive, indicating that the patient now has, or in some past time has had, a Brucella infection, or has possibly received a course of vaccine treatment, or may have drunk a great deal of milk containing the dead bacteria (pasteurized). If out of this maze one is willing to make a diagnosis of chronic brucellosis on the strength of a positive skin test, he is, indeed, a brave man, and in my opinion a foolish one.

What about a clinical diagnosis on the basis of physical examination and consideration of the symptoms offered by the patient? This, too, is very tricky business. The patient is "run-down"; he is "tired-out"; he is thin and does not eat well; he has many aches and pains, chronic arthritis or "rheumatiz"; his hands and joints possibly are stiff; lymphadenitis is common; sometimes abscesses develop at the site of an involved lymph node; he is "getting old too fast"; he has "always worked hard"; has been "out in the weather too much"; or he is losing his sexual power before his time. All of these, and many other "symptoms," might be mentioned.

Maybe these symptoms are due to chronic focal infection—that's what we used to say. Should he have his tonsils out, his teeth x-rayed and possibly pulled, or his appendix or gall bladder removed? Sometimes these symptoms look a great deal like tuberculosis, or chronic malaria, or a half dozen other conditions in no pertinent way related to brucellosis. An extremely careful physical examination with proper laboratory tests may eliminate this or that possibility as being a false lead.

HISTORY AND DIAGNOSIS

A careful history is taken. Has there been contact with hogs or cattle which possibly were diseased? Has unpasteurized milk been used? Has there been a story of contagious abortion in the home herd down on the farm years ago? Has there been a period of sickness diagnosed as malaria, typhoid fever, or tuberculosis that might have been an acute brucellosis?

Gradually using all of these hints, laboratory tests, skin tests—everything—there arises in the

mind of the physician the possibility that this is chronic brucellosis. Rarely, indeed, can he have the satisfaction of making a final, absolutely reassuring diagnosis. He undertakes specific treatment, or such treatment as would be expected to give relief from this infection. In case the patient shows improvement, it may be rather safely assumed that the diagnosis of chronic brucellosis is fairly well confirmed. It is not our place to discuss treatment in this article as that is to be considered in other articles in this issue of THE JOURNAL, by physicians with practical experience. Suffice it to say that the treatment for chronic brucellosis is very well worth trying. It cannot be promised to cure the disease, but degrees of improvement up to complete relief commonly are seen. This can be a form of practice which is not only lucrative and satisfactory to the physican, but also very beneficial to the patients. It is particularly effective in rural or swine-raising communities.

PREVENTION

Our purpose is prevention, when that is possible. Chronic brucellosis usually can be prevented by taking the best possible care of cases with acute brucellosis. Ambitious persons are loath to give up when they are ill. They want to keep on their feet as long as possible. Nothing is more foolish if the infection is actually an oncoming acute brucellosis. Then just as soon as the temperature goes down and a bit of strength has finally been garnered, the patient wants to get out of bed and go back to his work, which is already sadly neglected. This too, is most foolish from the standpoint of achieving a real cure. There is much to learn about the treatment of brucellosis, acute and chronic, but there is one basic principle which has been known by the peons of Mexico and the inhabitants of Malta for many decades, and possibly for centuries. It is this: the patient with this infection should go to bed, or should do whatever will give him the most rest. He should rest, rest, rest, and then rest for a month or six weeks more. It has been difficult to learn this lesson with regard to tuberculosis, which is a similar infection in many ways; it has been hard to sit by the side of the house while others work. Rest and high nutrition bear the same relation to this disease if we really wish to recover from it and avoid the chronic brucellosis which commonly follows an acute attack. It has been hard to learn that the patient with "flu"—and acute brucellosis may look like an attack of "flu," which does not clear up well and which leaves the patient mighty weak—must go to bed. It has not been easily learned that we must not overtreat "flu" or tuberculosis, but must depend upon the natural recuperative forces along with rest and nutrition, but we have done much better with these diseases since we have adopted these modern methods.

As preventive measures we would suggest that all possible exposure be avoided, and that persons suffering from the disease should stay in bed, keep quiet, and really "take it easy" until there is good reason to suppose that the infection has run its course. It will not do a bit of good to force the issue with this infection.

PROGNOSIS

The cumulative experience of thousands of practitioners and research workers tells us that this infection causes a great deal of suffering, discomfort, loss of work, ineffectiveness, and inefficiency. The number of deaths is not great, if we consider the straight infection only, but even so it probably far surpasses typhoid fever, of which so much has been said. Indirectly, it may be extremely injurious to health in obscure ways. We have in mind a diabetic who was barely able to get along on a rigid diet and a rather high intake of insulin. After a course of treatment for chronic brucellosis he gained twenty or more pounds, felt fine, improved greatly in his work, and required only half as much insulin although allowed a more liberal diet. Apparently the treatment made the difference between a well man and an invalid. It is impossible to say how much sickness or ill health may have as its basis an obscure infection of this sort.

As a rule, diseases improve as economic conditions and modern methods prevail. It is interesting that in several instances, at least, this tendency is likely to be reversed in brucellosis. As farmers get rid of their grade hogs and pay fancy prices for pedigreed animals they may introduce the infection, although there is no real need that they do so if they will but insist upon a bill of health—a certificate that the animals are free of Brucella infection —on each animal. The sale barns which are seen about the country, and the hog exhibits at fairs and stock shows obviously may serve to spread the disease. The improved method of cutting meat with a bandsaw may possibly be dangerous from the standpoint of spreading the disease to the housewife handling the cuts. Particularly is this significant when pork chops are cut, because one of the most common bony lesions in the animal is found in the involvement of the bodies of the vertebrae. It might be well if the housewife would scrape off this bone dust, and if she would avoid handling the chop with her hands, using a fork, and washing her hands immediately after handling the cuts.

RECOMMENDATIONS

It is impossible to say at this time exactly how serious the menace of brucellosis, acute and chronic, is, but there is certainly a rising tide of opinion to the effect that it may well be our most serious public health disease. A vast amount of research is needed. It should be said that this research is very expensive because it calls for the sacrifice of large numbers of research animals, chiefly hogs. This is no problem for a single individual doing research on a small scale. It will require huge governmental expenditures and the combined facilities of universities, boards of health, and research institutes, working in teams and assisting each other.

CONCLUSION

For purposes of summarization we present the following principles without elaboration:

1. This disease probably ranks fourth among infections, in the rural population at least, and may soon become first.

2. It is not well understood and should be the subject of much research.

3. It is very often not recognized by the public or the medical profession.

4. It should be regarded as an occupational hazard to veterinarians, farmers, and slaughter-house operators.

5. It may be transmitted by hogs, cattle, goats, horses, and possibly other animals, but swine are probably responsible for 70 per cent of it.

6. The swine and the goat forms of the disease are also more virulent than the bovine form.

7. It is believed that it is never transmitted from human to human. Mothers suffering from the infection have carried their babies to term and have nursed them without transmitting the infection.

8. Improved diagnostics are greatly needed, and should be supplied by hospitals, private laboratories, and boards of health.

9. Epidemiological studies should be made on each case of diagnosed acute brucellosis.

10. Rest and more rest is of greatest importance in treatment. A high state of nutrition is also beneficial.

CHRONIC BRUCELLOSIS

A Preliminary Report

M. J. MOSS, M.D.

YORKTOWN

One of the most protean of all diseases, chronic brucellosis often taxes the diagnostic ability of the physician.

An epidemiological history may be absent; the acute phase of the diease may never have existed; and serum agglutination titers are more frequently negative than positive. Blood cultures may well be expected to be negative in the chronic phase of the disease. Opsonic-phagocytic indices are ordinarily unobtainable, chiefly due to the risk of infection in technicians, and, although usually fairly reliable, may be of no aid.

The skin test constantly gives more diagnostic aid than the preceding tests. However, it may be positive in subclinical cases, in self-limited previous acute brucellosis, and in rarely false-positives. Likewise, the skin test may be negative in a small number of cases with a positive agglutination, and infrequently with positive blood cultures.

SYMPTOMATOLOGY

The symptomatology of the chronic phase of the disease is equally difficult. McGinty and Gambrell have forcefully brought this to our attention in describing one hundred fifty different manifestations of chronic undulant fever. The nervous system, cardiovascular, respiratory, gastro-intestinal, genito-urinary, and musculo-skeletal systems may be involved. The most common complaints have been those of extreme fatigue and exhaustion, headache, backache, chronic pyrexia, weight loss, arthralgia and myalgia, insomnia, excessive perspiration, and night-sweats. Other less frequent findings are cough, intermittent pleuritic pains, bronchitis, vertigo, constipation, vague abdominal symptoms, hepatomegalia, splenomegalia, cystitis, pyelitis, orchitis, prostatitis, oophoritis, functional menstrual disorders, sexual impotence, apprehension, and various other manifestations of involvement of the central nervous system.

There is some evidence that the endotoxin of Brucella strains circulating in the blood have some predilection for the central nervous system tissue.

The frequency of central nervous system symptoms gave rise to the famous statement of Alice Evans,[1] "These facts challenge the right of a physician to make a diagnosis of neurasthenia without considering, among other possibilities, the possibility of chronic brucellosis."

Chronic brucellosis may arise many years after the original infection, as indicated by the epidemiological history. In all probability a symbiosis occurs during this interval, the organism being harbored in the lymph nodes, spleen, liver, and reticulo-endothelial system, and the initial onset occurs when the symbiosis is disturbed by physiological factors in the host. The onset of symptoms may occur any time after a definite exposure, or after repeated minor exposures to the organism.

DIAGNOSTIC PROCEDURES

The wide variety of symptoms requires a discussion and an evaluation of the diagnostic procedures that are available to the general practitioner, for it is the physician in the rural communities who will see the greater proportion of these cases.

As previously stated, blood cultures are obviously of little benefit in the chronic phase of the dis-

[1] Evans, A. C.: Studies on Chronic Brucellosis IV—An Evaluation of the Diagnostic Laboratory Tests, *Public Health Rep.* 53:1507-1523, 1938.

ease, only a small percentage being positive, and then only during an infrequent relapse into the acute phase.

The agglutination serum titer has long been a dependable diagnostic test in acute brucellosis, the agglutinins appearing several days to several weeks following onset. Many physicians refuse to consider a diagnosis of chronic brucellosis unless a positive agglutination finding is present. (This fallacy has been refuted by Huddleson,[2] who reported that 86 per cent of the chronic, ambulatory cases have negative agglutination tests.) Accordingly, in interpreting this test only confirmative findings may be considered, and negative tests have no significance in establishing a diagnosis.

Inasmuch as the opsonic-phagocytic index is not obtainable in this community, it will not be discussed.

The skin test is the most reliable single diagnostic office procedure at the present time. Benning[3] has described the immunological process extremely well, using Huddleson's Brucellin skin test material, and comparing the reaction to Schwartzman's phenomenon.

Briefly, the reaction to the skin test is the response of sensitivity of the endothelium of the capillaries developed from pre-existing allergic or sensitivity changes from Brucella protein over a period of time, in response to a homologous protein injected into the skin. This occurs only if a homologous endotoxin or protein is still circulating within the capillary bed. Hence, a positive reaction signifies that these split protein fractions of the organism remain in the circulatory system regardless of whether or not symptoms are present.

The skin test in this respect is specific, the only organism resembling molecular protein structure being tularemia, as indicated by overlapping agglutinin response in some instances. Overlapping agglutination tests should be ruled out by agglutination absorption tests. The incidence of tularemia is so negligible that it would rarely be necessary to consider it in regard to a positive skin test.

The author has used skin-testing material and vaccine prepared by Foshay's method exclusively. At present it is not available for general use.

In doing the test 0.05 cc. of the skin-testing material is injected intradermally into the forearm, and the reaction is observed after forty-eight hours. A positive reaction consists of a small area of induration with surrounding erythema about the size of a quarter, or larger. Various streaks of erythema may or may not extend from the circumscribed area. The more sensitive cases experience skin necrosis and sloughing, axillary adenopathy, chills and fever, and generalized aching. The induration is more prolonged than the erythema.

[2] Huddleson, I. F.: *Brucellosis in Man and Animals*, Second Edition, New York, Commonwealth Fund, 1943.

[3] Benning, H. M.: Chronic Brucellosis, *J.A.M.A.* Vol. 130, No. 6, (February 9) 1946.

Since January, 1946, skin tests have become a routine procedure in our office in all cases having a history of chronic fatigue and exhaustion, arthralgia and myalgia, and in which there is an absence of physical findings, with or without chronic pyrexia. Slightly more than four hundred skin tests have been given over this period of time. Of this number about nineteen per cent have been positive. No cases are treated unless the symtomatology warrants it regardless of the results of the skin test, for some of these cases may well be considered sub-clinical or self-limited.

At this date seventy-four of our patients are in various stages of treatment. The variety of symptoms of the group that are fairly constant are related in Table I. Seven other cases have voluntarily discontinued treatment for various reasons.

TABLE I

PREDOMINATING SYMPTOMS OF SEVENTY-FOUR PATIENTS

Symptoms	*Number of Patients*	*Per Cent*
1. Fatigue	74	100
2. Arthralgia and myalgia	74	100
3. Nervousness and irritability	56	75.6
4. Headache	21	28.3
5. Chronic pyrexia	49	66.2
6. Gastro-intestinal	34	45.9

Fatigue, muscular and joint aching and pain have been constant in all patients in this group. The intensity of the extreme fatigue is startling in some cases. Many patients have told us that during shopping tours it has been necessary for them to sit down on the curb and rest, or lean upon a parked automobile before continuing. Farmers have stated that they have to lie down in the field at intervals before resuming their activities. Others can perform only about a half day's work and bed-rest then becomes imperative. Many have quit their jobs because of increased fatigability. Pain in the leg, arm, shoulder, and backache lead to insomnia in varying degrees of severity.

The high degree of chronic pyrexia is amazing. Fever is found in the afternoon or evening during the greatest period of fatigue. Some patients have had fever constantly for three to four years. Others have had intermittent attacks of low-grade pyrexia lasting for months, remitting and then recurring. Nine of these cases are children, ranging from three to ten years of age. Chronic fever has been discovered during routine physical examinations and in pre-tonsillectomy routine check-ups. Chronic pyrexia in any case signifies a focus of infection. The case must be thoroughly investigated and all causes of chronic fever must be considered before a diagnosis of chronic brucellosis may be established. All children are tuberculin-tested, and roentgen, sedimentation rate, and blood studies are made in all cases possible. Five of the nine children have had repeated upper respiratory infections and a moderate secondary anemia. A few children were treated for two months with bed rest, but did not improve until after vaccine was administered. Chronic brucellosis may be found at any age.

Nervousness and irritability accompany chronic fatigue. Apprehension, lack of ambition, mental depression, and occasional hand tremors are present. Two individuals were almost on the point of chronic alcoholism, which tendency began after the onset of their symptoms. A typical remark is, "Life is hardly worth living." Headaches are also part of the central nervous system involvement.

The gastro-intestinal symptoms are bizarre. One peptic ulcer case was discovered in these thirty-four cases, which was substantiated by x-ray. Symptoms of peptic ulcer occurred three months after the onset of chronic brucellosis in this case. Although it has been impossible to obtain roentgenological studies on all these patients, clinically, I feel that the remaining do not have organic gastro-intestinal disease. Most of these patients complain of an intense burning in the epigastrium, which may occur at any time. Others complain of abdominal cramping, indigestion, biliousness, bloating, gnawing sensations in the epigastrium, and constipation.

Only nine positive agglutination tests have been obtained from the entire group, 12.1 per cent. This compares favorably with Huddleson's[2] results, which have been mentioned previously. The agglutination serum titers of the nine cases have varied from 1-40 to 1-640.

A few complications have been noted. One patient with a chronic corneal ulcer of two year's duration has been receiving vaccine treatment, but without very marked success. One case of chorioretinitis has also been verified by consultation and has improved considerably with vaccine therapy. Variable types of arthritis have developed in nine cases following the onset of chronic brucellosis. Three are of the mixed type, two are atrophic, and four are hypertrophic. All three cases of the mixed type developed within one year after the onset of brucellosis, and all have had relief of pain and improvement of motion following therapy. In the other cases the arthritis may have been a coincidental finding.

THERAPY

The administration of vaccine prepared by the Foshay method is somewhat of a departure from previously-accepted methods of other brucella vaccines. The material is standardized by the usual turbidity method in varying dilutions. Every effort is made to keep the dosage below the reaction point. Reactions, when they do occur, consist of an exacerbation of the symptoms which previously have been noted.

Many vaccines now being used are given in such a manner that extremely severe reactions occur, to the extent that the patient refuses to continue his treatment. One wonders if non-specific protein therapy might also give some therapeutic result.

All inoculations are given subcutaneously, and may be given daily or three times weekly. This group has received the vaccine three times weekly because of the convenience to the patient. The initial dose is 0.05 cc., varying from T1/50 to 1/1,000, depending upon the sensitivity of the patient as regards the severity of reaction of the skin test. No patient receives vaccine until the skin test has receded to a minimal size in view of the possibility of a Schwartzman's reaction. The initial dose is repeated on the third day, and then 0.1 cc. of the same dilution is given for two doses at the prescribed time. This method is continued with each decreased dilution, two injections of 0.05 and two of 0.1 cc. three times weekly, in which the turbidity is increased until the maintenance dose of 0.1 cc. of T/50 is reached. The inoculations are given for nine months to one year, the skin test being repeated at intervals, and usually found negative at the end of nine months.

A great variability of sensitivity to the vaccine occurs at the time of the initial dose. One individual had rather severe reactions to a dilution of .05 cc. of T 1/10,000,000, consisting of chills, fever, and aching for three days. The same reaction occurred on a dose of .05 cc. of T 1/100,000,000, and his therapy was then begun with T 1/500,000,000, an almost infinitesimal amount of vaccine. He has had a reaction several times since then with increases of dosage, and in one instance hospitalization was deemed necessary. It is doubtful if vaccine therapy can ever be administered to this patient in view of his extreme sensitivity to Brucella protein.

Most individuals tolerate the initial dilution of T 1/100 very well. The succeeding dosage depends entirely upon the reactions that occur, if any. All cases that react are placed upon a higher dilution of vaccine until reactions are not observed.

Patients are also variable as to the potency of the maintenance dose they may receive. The highest concentration of T 50 is desirable. One relapse occurred after a two-month freedom from pyrexia. This resulted from over-antigenization with T 50, and subsequent reduction to T 6 has produced remission of symptoms and freedom from pyrexia. One other patient has never been able to receive a maintenance dose of over T 1/100 dilution without exacerbation of symptoms. The maintenance dose of vaccine depends entirely upon the patient's reaction.

Relief of symptoms occurs in three to twelve weeks. The improvement is usually steady and slow, and rarely dramatic. The best index of satisfactory progress is the increased ability to perform more work, and a decrease in the symptoms and complaints of the patient.

The long administration of a maintenance dose of vaccine may give rise to some question as to its necessity in view of marked improvement within a few months. There are two main reasons for this. The number of recurrences of symptoms is remarkably high in cases in which inadequate immunization is obtained. The low antigenicity of the Brucella organism is well known, and this writer feels that a prolonged immune response to vaccine is

essential to prevent recurrences or relapses of chronic brucellosis. Perhaps this will later be clarified by Foshay, for he has had an opportunity to observe a large series of cases, over a period of many years, under similar therapy.

CASE REPORTS

Three typical cases are presented as excellent examples of chronic brucellosis:

Case 1.

E. G., a female, aged thirty-two, weight 107, was first seen in the office on December 14, 1945. The outstanding complaints consisted of low-grade temperature of over three years' duration, chronic fatigue and exhaustion, and arthritis of the left wrist and hand and right ankle, associated with pain on movement and swelling. Vague, intermittent, inconstant chest pains were present.

Onset of the illness began in April, 1942, about seven days after visiting relatives on a farm in the southern part of the state. The patient drank raw milk during this visit, and had always used pasteurized products in her own home. Onset consisted of temperature, generalized aching, and chills. About ten days after onset both ankles and the right wrist and hand became swollen. The left ankle finally cleared up, but residual swelling, stiffness, limitation of motion, and pain persisted in the right ankle and left wrist and hand. During the past three years this patient has received penicillin, sulfa products, cauterization of the cervix, teeth extraction, and physiotherapy to the affected joints, all without benefit.

The epidemiological contact was established in March, 1942, with onset of the disease in April, 1942. After investigation the herd was found to have had Bang's disease in the summer of 1942, although the patient was not informed thereof until this year.

Physical examination was negative in all respects with the exception of the presence of arthritis in the above-mentioned joints.

Laboratory findings consisted of the following: R.B.C., 4,650,000; Hgb., 90 per cent; W.B.C., 8,900; differential count normal. Sedimentation rate 11 mm. in one hour. Urinalysis normal. Serum agglutination for brucellosis was negative on two occasions. Skin test was positive. X-ray of chest was negative. X-ray of right ankle revealed a mixed arthritis.

The progress of the disease is interesting. She was able to remain at work until April, 1945, and although all housework was discontinued the patient usually collapsed in bed after eight hours' work at a factory. For over a year it has been necessary for her to remain in bed every afternoon, and physical exertion has been impossible, even light housework.

After four months of vaccine therapy this patient became temperature-free, with complete remission of general symptoms. She has returned to her industrial occupation and in addition is doing the greater part of her housework. The arthritic changes have improved considerably with reference to pain and improvement in motion. No swelling has existed during the past three months. Vaccine therapy will be continued for one year.

Case 2.

J. H., a farmer, aged forty-three, weight 142, was first seen on December 29, 1945. Onset of symptoms began three months previously, with fatigue, inability to work without rest periods, and intense burning and pain in epigastrium not related to food intake or variety. This patient had convinced himself that abdominal pathology was present. Gastro-intestinal, choleogram, and barium enema were negative. Serum agglutination for brucellosis was negative. Patient refused a skin test, and was treated symptomatically until May, 1946, without improvement. Skin test at that time gave a severe reaction with fever, axillary adenopathy, exacerbation of gastro-intestinal symptoms, and subsequent sloughing of the local area. Chronic pyrexia was not present during this illness. No definite epidemiological history could be obtained other than repeated exposures during his entire life. Vaccine therapy was started on May 4, 1946.

His progress had been extremely satisfactory, improvement beginning within six weeks. At present his work capacity has more than doubled, and he is symptom-free with the exception of an occasional gastro-intestinal upset. Further therapy should give complete relief from this symptom.

Case 3.

C. H., aged forty, a meatpacking house employee for sixteen years, and a farmer, had complained of severe occipital headaches, fatigue and exhaustion, irritability and nervousness, a severe burning sensation in his stomach, and occasional pain in his knee for the past three years. He had had previous symptomatic treatment and ulcer therapy without relief. Fever had never been detected during that time, to his knowledge. The fatigue was sufficiently severe to prevent his doing but very little evening farm work after the completion of his packing job, and he spent all of his spare time in bed. He had a cardiac irregularity consisting of "dropped beats" more frequently upon exhaustion during this period. Other cases have also complained of this symptom. Gastro-intestinal, choleogram and barium enema were negative in November, 1945. Physical examination was completely negative.

Bang's disease had never been present in his farm stock. He feels that the contact is probably of the suis strain derived while butchering.

Vaccine therapy was instituted on June 1, 1946. Improvement began about the sixth week, with steady improvement until now when he has been asymptomatic for the past three weeks. His work capacity has increased sufficiently so that he can take care of his industrial work and also his farming with very little fatigability. Gastro-intestinal symptoms and headaches are completely absent.

No attempt has been made to determine the incidence of the disease in this community. The

greater number of these cases come from within a rather wide radius. Most of them are farmers, farm-wives, or suburban dwellers that have, or have had, some stock, access to raw milk, or who butcher their own pork or beef. Only four have a history of one individual contact connected with the onset of their illness, which arose shortly after that contact.

Most of the therapeutic results have been excellent, but eight cases have definitely shown no improvement after three- to five-months' therapy. Other chronic medical problems are present in six of these cases. The possibility exists that chronic brucellosis may be present and that it does not respond to vaccine therapy; that it does not exist; or that it is present in a subclinical phase. No laboratory tests are available to deny or confirm these problems; hence, the possibility of poor clinical judgment must be entertained in these patients. Nevertheless, few chronic medical therapeutic problems will give 90 per cent good to excellent results.

The best indication of recovery consists of remission of symptoms, which undergo complete resolution or become so transient or infrequent as to be almost negligible. The increase in work capacity and return to productivity solves many economic problems. The recovery from chronic fatigue, depression, and severe, vague gastro-intestinal symptoms has resulted in a great deal of satisfaction both to the patient and to the physician.

SUMMARY

1. In general, the constant features of chronic brucellosis are chronic fatigue and exhaustion, arthralgia and myalgia, occasional vague gastro-intestinal symptoms, mental depression and apprehension, with or without chronic pyrexia, and a complete lack of physical findings. An epidemiological history of contact is necessary, but it occurs all too frequently in rural communities.

2. Agglutination serum titers are of little significance, the greater number of cases being negative; and even when positive a diagnosis can be made only when adequate symptoms are present. The opsonic-phagocytic index is desirable when obtainable.

3. The skin test is the most reliable and the most convenient test for the general practitioner. A positive skin test associated with symptoms of chronic brucellosis, a positive epidemiological history, an absence of a demonstrable cause of chronic pyrexia or fatigue, and an absence of physical findings must be considered as being indicative of chronic brucellosis in the greater number of cases.

4. Seventy-four cases of chronic brucellosis have been treated with vaccine therapy. Over 90 per cent have had good to excellent results with relief of symptoms.

SYMPTOMATOLOGY AND DIAGNOSIS OF CHRONIC BRUCELLOSIS

NEAL DAVIS, M.D.

LOWELL

The interest in brucellosis has increased greatly in the past four years. In 1940 a paper was written by the author[1] to establish the fact that this disease has a chronic phase. Today the literature contains numerous articles on this phase alone.

Brucellosis is nation-wide in its distribution, and it has been estimated that 12 per cent of our population is infected by one of the many complex phases of this disease.

The greatest number of cases is found in our rural areas; however, it is not illogical to estimate that our entire adult population has at some time been exposed to the Brucella organism. What person, at some time or other, has not ingested raw milk or dairy products made from unpasteurized milk? After a person becomes infected with this organism a variety of courses may ensue. When an acute Brucella infection is encountered, the patient who is acutely ill is usually hospitalized, where clinical study and laboratory findings aid in the diagnosis. From this point he may develop an immunity, or he may go into the chronic phase. Or, from the onset of the disease he may enter the chronic phase, where he becomes a misery to himself and a headache to the physician. This ambulatory patient may at any time have an exacerbation of his symptoms which resembles that of the acute stage.

The symptoms of Brucellosis have been described by many authors. Fowles[2] states:

"The symptoms of brucellosis are as variable as those of any known disease, including the great mimicker, syphilis. Acute brucellosis usually follows after a trying period during which the patient has endured unusual physical fatigue and mental anxiety. A high fever develops, producing marked exhaustion or prostration. In some cases the temperature follows an undulating pattern; hence, the term 'undulant fever,' which has been used to describe the disease. In general, this term is a misnomer, as many patients are fever-free or fail to notice the temperature rise unless they

[1] Davis, Neal: Chronic Brucellosis, *Jr. Ind. St. Med. Ass'n.*, 36:459-461, Vol. 9, (Sept.) 1942.

[2] Fowles, Everill W.: Physical Therapy As an Adjunct to Artificial Fever in Brucellosis, *Arch. Phys. Med.*, 26: 628 (October) 1945.

have chills and diaphoresis. Sudamina generally occurs during the third week of the illness and usually has a disagreeable musty or field-mouse-nest odor. It may be present at any time, but is usually more profuse in the morning. Dyspepsia is common and is often accompanied by either constipation or diarrhea. Many patients show secondary pronounced reduction in hemoglobin content, with resultant ashen-gray facial pallor. The hips, shoulders, ankles and knees are often swollen but not reddened, and the patient complains of severe muscular and joint pain. Distressing basilar-type headaches with pain and stiffness of the cervical part of the spinal column are not uncommon. Soreness of the mouth and bleeding of the gums are frequently noted in acute cases. Additional findings are mild leukopenia, adenitis, insomnia, scrotal edema, orchitis, colitis, mental confusion, abdominal distention, meningeal irritation and painful enlargement of the spleen. The most common complications and sequelae are the orthopedic and gastro-intestinal ones. Spondylitis is the most common orthopedic complication. Cold abscesses occur in a few cases, with the hip the favorite site; however, the humerus, ribs, skull, and wrists have also been involved. Ulcers may occur in both the large and small intestine, and may give rise to severe pain or even hemorrhages. Nosebleed is often associated with these conditions, and the patient not uncommonly mentions a girdle-like constriction about his waist or pelvis. Patients with rectal ulcers often complain of bright red bleeding and may treat themselves or be treated by their physicians with hemorrhoidal remedies, without relief."

Carr[3] describes the disease as follows:

"In cases of undulant fever there is usually a mild indisposition with anorexia and headache; sweating is often marked. The general condition of the patient remains good in spite of the high temperature and the profuse sweats. The pulse rate is slow in proportion to the rise of temperature. In some cases the patients continue at work, being annoyed only by a sense of fatigue at the time of day when the fever is highest. The characteristic feature of the clinical course is that which gives the name, 'undulant fever,' to the disease—the long duration of the disease with alternating exacerbations of fever, often high, and periods of remission during which no fever is present or only a slight rise occurs occasionally. These periods of fever alternating with afebrile or subfebrile periods may persist for months, even a year or more.

"To these symptoms may be added anemia, loss of weight, strength and morale, which are especially associated with the type of disease characterized by severe acute arthritis. Enlargement of the spleen is almost always present; its absence raises a question as to the accuracy of the diagnosis. The leukocyte count is characteristically low, with a relative lymphocytosis. . . . Lymphatic glands are frequently enlarged. The liver may be enlarged; sometimes tender. There may be transitory erythematous or roseolar eruptions, even varicella-like eruptions and bullous dermatitis. The outstanding features are the characteristic fever curve, with remissions and marked exacerbations, the sweats, enlargement of the spleen and lymphatic glands, leukopenia with relative lymphocytosis, a pulse rate slow in relation to the height of fever, and the generally well-maintained physical condition in spite of these symptoms.

"Furthermore, (and this is an important feature) undulant fever often produces various local types of disease. Chronic arthritis of a single joint or of several joints may occur; spondylitis had been reported frequently; hydrops of a single joint is an occasional finding. Chronic subcutaneous abscesses, cholecystitis, encephalitis, meningomyelitis, neuritis, adenitis, mastitis, thrombophlebitis, pleurisy with effusion, and endocarditis have all been reported. Orchitis and epididymitis occur, not so often as an isolated or presenting symptom, but as a part of the general infection."

After reviewing the literature one is impressed with the following:

Weakness: These patients are well-nourished, usually have a good appetite, and rest well at night, yet they arise in the morning exhausted, and find it difficult to move from their bed. As the day goes on they gain strength, only to lose it again the next morning.

Pain: It is usually the pain that drives them to the doctor. This pain is vague and ill-defined. The pain may be in the chest, in which case it resembles angina; or it may be a backache; or pain in the lower extremity or in the abdomen, but one seldom encounters point tenderness which persists. In the acute case the patient always has fever, while the chronic case seldom shows such a symptom. A mental depression or emotional instability is usually encountered in the patient with a chronic form of this disease.

Upon localization the symptoms will be expressed by the focus of the infection, such as brain abscess, pneumonia, iritis, or osteomyelitis. No tissue is exempt, and any point in the human body may become the seat of the focal infection or cold abscess.

The diagnosis of the acute infection of Brucella is most readily accomplished by laboratory methods. The unexplained fever demands a clinical study, and a blood culture or high titer comes to the rescue of the puzzled physician. The diagnosis of the chronic form is quite another story. It enters the realm of art rather than science. The most positive of all criteria is the blood culture. However, there are few laboratories in our country capable of making this elusive bacteria grow, and

[3] Carr, James F.: The Symptoms, Diagnosis, and Treatment of Undulant Fever, *Ill Med. Jr.*, 73:521, (June) 1938.

the availability of such laboratories to the general practitioner rules out this diagnostic agent.

In the hands of a good technician the phagocytic index is a help; however, much controversy has risen over its exact value. In itself the phagocytic index indicates only the degree of opsonic activity of the blood toward Brucella. It is best used as an indicator of the progress of the disease, rather than as a diagnostic aid, and should never become a tool of a practitioner.

The skin test and the agglutination tests are relied upon for diagnosis. Our literature has reported many cases in which one or the other of these tests, and sometimes both, have been negative in the presence of active infection as proved by positive blood culture. How then may we make a definite diagnosis of brucellosis? In the acute case the exclusion of other infections, the overwhelming evidence from high titers of agglutination, high phagocytic index, leukopenia with a relative increase of lymphocytes, splenomegalia, and a possible positive blood culture assures one of the nature of the infection with which he is dealing.

On the contrary, when one encounters a patient who has "undulant fever" without fever, a skin test, which, if positive, only justifies one in saying that the patient has, or has had, brucellosis; and when a positive agglutination test may be confused with agglutinin from B. typhosus, B. tularensis, B. proteus x 19, and cholera, we are forced to ask the question, "Is it ever possible to be sure of a diagnosis of chronic undulant fever?"

In many cases we can not make the diagnosis until the patient has undergone many tests and much observation, including a therapeutic test of vaccine. However, the diagnosis is usually quite obvious. Many patients come to the physician with a history of the ingestion of raw milk from a herd of cows recently found to have Bang's disease. The patient's unexplained weakness, unusual behavior of the heart, generalized pain, and any positive laboratory findings make the diagnosis quite clear. Any doubts may be removed by giving a large dose of abortus vaccine, which would be followed by an acute exacerbation of all symptoms if the condition is due to chronic brucellosis.

Treatment of infectious diseases has changed so rapidly in recent years that any statement can become obsolete by tomorrow's newspapers. The treatment used in brucellosis has undergone a typical history: vaccines, sulfonamides, artificial fever, penicillin, and now streptomycin.

A review of the literature will reveal a number of cases treated by each of these measures, yet no author is willing to say that any one agent or procedure will cure all cases. This is due to the fact that Brucella is able to localize itself in any tissue of the body, and a therapeutic agent which will penetrate a joint or bone may not be effective in the spleen or nerve tissue. The infection usually enters the body by way of the digestive tract. If its primary focus remains there then sulfasuxidine can be expected to cure it. If, however, the blood stream is entered, and any other tissues are invaded, this agent is of no value. It is then probable that the other sulfonamides may be effective. Spink and Hall[4] use the sulfonamides, and add artificial fever to the cases which respond slowly. Penicillin has proved to be a disappointment, but the story may be different with streptomycin, Reimann,[5] Goelz,[6] and Herrell[7] each report cases cured with this antibiotic substance. Their cases have all been acute, but their success holds hope for the future.

[4] Spink, Wesley W., and Hall, Wendell H.: The Diagnosis and Treatment of Brucellosis, *Med. Clin. N. Amer.*, **29**:343 (March) 1945.

[5] Reinmann, Hobart A.; Price, Allison H.; and Elias, William F.: Streptomycin for Certain Systemic Infections and Its Effect on the Urinary and Fecal Flora, *Arch. Int. Med.*, **76**:269 (Nov.-Dec.) 1945.

[6] Goelz, John R.: Treatment of Undulant Fever with Streptomycin, *Wisc. Med. Jr.*, **45**:496, (May) 1946.

[7] Herrell, W. E., and Nichols, D. R.: The Clinical Use of Streptomycin: A Study of Forty-five Cases, *Proc. Staff Mect. Mayo Clinic*, **20**:449, (Nov. 28) 1945.

ABSTRACTS

TIME-DOSE RELATIONSHIP IMPORTANT IN PENICILLIN TREATMENT

Penicillin, given in large doses over a relatively long period, is the only effective treatment of the once fatal disease known as "subacute bacterial endocarditis," according to an article in the December 22 issue of *The Journal of the American Medical Association.*

Arthur L. Bloomfield, M.D., and Richard M. Halpern, M.D., of the Department of Medicine, Stanford University School of Medicine, San Francisco, wrote that at the present time the best treatment seems to consist of four to eight intramuscular injections of penicillin every twenty-four hours, with a total daily dose of at least 200,000 units continued over a period of two months.

The doctors emphasized the importance of the time-dose relationship because otherwise the patient may lose the advantage gained by an early diagnosis. By the time a relapse occurs, due to inadequate dosage in the initial treatment, the infecting bacteria may develop increased resistance to penicillin.

Subacute bacterial endocarditis usually attacks valves of the heart that are already damaged. In several of the patients heart failure occurred after the disease was under control. The authors explained that unless treatment is started early, irreversible damage to valves may occur even though penicillin eradicates the infection.

THE PRACTICE OF MEDICINE IN RURAL AREAS*

JESSE E. FERRELL, M.D.

FORTVILLE

We all are aware of the alarm that is being sounded from one end of the country to the other in regard to the lack of sufficient medical care for America's rural population, care which our farm people so justly deserve. This situation should not exist, and must not be permitted to continue, for agriculture is one of the most essential cogs in our economic machinery. Without the farmer and his family producing as they do, the entire world would suffer for want of proper nutrition and many other essentials that come directly or indirectly from the soil. We cannot afford to neglect our fine farmer folk. I have spent forty-three years in the practice of medicine among rural people, and I say with all sincerity that they are the salt of the earth.

For a number of years farsighted men and women have been alert to the decline in the number of country doctors, and have put forth every effort to get before the public some plan to combat this evil trend. Forty years ago the country doctor was a community fixture. He was practically lord of all he surveyed, and being a friend to everyone he was consulted on business transactions and private affairs, as well as matters of health. His advice was sought on such subjects as horse-trades, the purchase of a family car, or where John or Mary should go to college. The physician was also the confidant of young people who came to him to discuss many important topics that concerned them, including affairs of the heart. In fact, it may be said that the physician's advice was the ultimate in decisions made by families living in the community.

Most of the doctors of the early days did not have broad technical knowledge, but they possessed a high degree of common sense. As an example, the preceptor under whom I served as an apprentice had had only two years in a medical school, but he was a very fine diagnostician. And, above all, he was a kind, sympathetic, and understanding man who always was ready to help anybody in need.

The high position of the country doctor in the community was more or less an incentive for young graduates in medicine to locate in such surroundings. The rural practitioner was the ideal and envy of the young doctor who longed to attain a like place of high affection in the hearts of his patients. The economic side, too, played a large part in the young doctor's decision to practice in a small town, for rural people always have been known for their honesty, and the young physician could be sure of collecting seventy-five per cent of his fees.

Also, in this era of which I am speaking there were more doctors per capita. And remember, this was the horse-and-buggy era, and doctors were obliged to be near their patients. One might say that this type of practice was the finishing school for the young doctor. Ofttimes the young medic would practice in the rural community, gaining knowledge and training until he felt capable of establishing himself in the larger and busier urban centers. There, many of them became our best physicians and surgeons, and no little credit should be given to the basic training they received as country practitioners.

In my opinion, this type of training for beginning doctors was a very good thing. Could it not be termed a rotating service? And might it not be a solution of the present problem if medical school graduates were required to practice a year or two in a rural community as a part of their education?

Let us now direct our thinking to the rural population and see what has happened to it in the past twenty or twenty-five years. First, there has been a marked advancement in education. The boy and girl living in the country is now as highly educated as their city cousins, and they are equally as progressive. Fifty years have brought great changes, too, in the overall perspective of the rural resident. He is demanding the better things of life, and better medical care is among them. In the field of preventive medicine, such as better sanitation, proper food, immunization of children against communicable diseases, et cetera, the farmer is keeping step with his fellow citizens in the city. All of this has come about by the changing manner in living conditions, principally the coming of the automobile, which has lessened space and distance. We could go on and on enumerating the advances up to the present atomic age, with all its immediate possibilities.

What is the solution of the problem of adequate rural medical care? We can only discuss this and make some recommendations which may prove helpful.

The young physician of today is a highly-trained individual. He is required to have a complete knowledge of the basic sciences and then progress to a full understanding of the workings of the human body, both in health and disease. Then he must possess the "know how" of the treatment to be applied to effect cures. All of this entails great energy and the will to succeed; the student cannot falter. He must know these things before he receives his diploma from medical school. Then comes the final training in a hospital—his intern-

* Address delivered by J. E. Ferrell, M.D., Fortville, president of the Indiana State Medical Association, at the Conference on Rural Medical Care, Purdue University, Aug. 1, 1946.

ship—where his knowledge is applied under close supervision. After nine or ten years of this type of guidance, is it any wonder that the young doctor is so thoroughly imbibed with the idea that good medicine cannot be practiced except in surroundings similar to that in which his training was received? I don't think that we should criticise the doctor for not wanting to practice medicine in a community which does not have these facilities.

Could the training of these medical students be changed enough that, say in their junior year, they would receive a few hours of instruction by a practitioner in rural medicine, the course to be worked out so as to stress the advantages of such a practice? Wouldn't it be possible to distribute these students among the doctors in rural practice, for at least a long enough time for them to learn the technique of a bedside-working diagnosis without the aid of x-ray and laboratories, thus instilling confidence in them by teaching them to rely upon their own diagnosis?

I would like to cite another factor that influences the student in reaching his decision as to the type of practice he will follow. The teachers under whom he receives his instruction are, for the most part, specialists in their particular fields of medicine. These men command large fees, and it is only natural that the student wishes to do likewise as soon as possible. Therefore, the student will concentrate on one branch of medicine so that he may become a recognized authority, and it is then necessary for him to practice in some large urban center. This is bad, in a general way, for American Medicine. We all can see that if this trend does not stop of its own accord, then legislation might arise to curb specialization. This we do not want.

More rural hospitals or diagnostic centers are suggested to provide better facilities for the care of people who live in sparsely-settled areas, and to make country practice more attractive to doctors by providing adequate and convenient treatment centers. This sounds very fine and logical, and medicine can go along with such a program, but there are numerous problems which must be solved before a definite start is made.

In establishing a hospital, even a small one, the question immediately arises, "Is there competent medical and surgical personnel available to staff it?" Also, there must be enough nurses, and I am of the opinion that this presents about the biggest problem. Far too few young women are taking nurses' training at this time. Just a couple weeks ago I had the pleasure of participating in a radio program over one of the Indianapolis stations in which an appeal was made to the young women of our state to enter nurses' training. We should all support this program and encourage more girls to take up this humanitarian work as a career. Our present hospitals are woefully short of nurses.

The diagnostic center is a large question mark to me personally. This would be very easy to establish, but again the problem of operating it will be great. Of course, these can and must be overcome. I am sure that all the rural doctors will cooperate to the best of their ability.

And again, let us all remember that we are living in an age of rapid progress and change. Decisions must be made rapidly and not put off from month to month, because if we fail, then the monster of socialized medicine raises its head higher and higher, and the next thing we know the government will step in and take control. I am sure that there is not one here who wants to see government medicine. We must all work to retain our individual freedom, our free and unincumbered right to select the physician of our choice.

In closing, I would like to leave one little word of advice to you farm people. It is offered in the greatest spirit of friendliness. Many of you still have a country doctor in your community. Don't drive by his door into the city for medical treatment. Don't do this, I say, if you want to keep your doctor. He can't exist without patients.

I sincerely appreciate the opportunity you have given me to appear before you to discuss some of the problems of better rural medical care. I am confident that by working together—you good farm leaders and the medical profession—we will be able to arrive at a satisfactory solution of this grave problem.

ABSTRACT

PENICILLIN IN SKULL INFECTIONS

Penicillin offers the patient suffering from infections involving the central nervous system and skull the most effective and rapid way to recovery, according to five San Francisco investigators.

Writing in the August 10 issue of *The Journal of the American Medical Association*, H. C. Naffziger, M.D., Helen Warmer, A.B., Walter E. Stern, M.D., Roberta Fenlon, M.D., and H. J. McCorkle, M.D., from the Division of Surgery of the University of California Medical School, say that during the past two years they gave penicillin to thirty-seven patients with infections involving the central nervous system and skull.

Treatment consisted of penicillin injections into the muscles at three-hour intervals, lasting anywhere from six to one-hundred fourteen days. The total dosage of penicillin varied from 745,000 units for those patients with infections of the skull bones but no central nervous system involvement to 36,500,000 units for patients who had signs indicating localized areas of infection within the skull.

The authors say that the response to penicillin treatment was very good in nearly all cases, often referring to the results as "excellent."

The article points out that "in three patients with pneumococcic meningitis definite localizing signs were observed, indicating intracranial abscesses originating from acute mastoiditis. Although the surgeons declined to operate on these three patients because of their critical, apparently hopeless condition, all three recovered after prolonged penicillin therapy."

THE GENERAL PRACTITIONER IN A PUBLIC HEALTH PROGRAM

L. E. BURNEY, M.D.*

INDIANAPOLIS

Around the general practitioner, who represents medical science with all its progress in the prevention and treatment of disease, must be built the public health program. A well-informed and cooperative group of general practitioners can be the greatest asset of the state health officer and the local health officers. The general practitioners care for most of the sick, and upon them falls the responsibility of returning the sick to health and productivity. Their contribution to these goals is considerable, and, unfortunately, is not always recognized and appreciated by the recipients of the care or by a few other well-meaning, overzealous individuals.

No branch of medicine has had a more rapid growth within the last twenty years than that of public health. An editorial in *The Journal of The American Medical Association*[1] has the following to say: "A major reason for inadequate civilian health protection in war as in peacetime was a failure of many states and counties to provide even minimum, necessary, sanitary, and preventive health services by full-time, professionally-trained, personnel. . . . The career of public health as a specialty of medicine requiring graduate university training and experience is so far accepted as a part of the pattern of preventive medicine that the survival of the part-time general practitioner as the local administrator of a health department cannot be encouraged by the medical profession or be recommended to the taxpayer as the best his money can buy in public health."

DEFINITION OF A PUBLIC HEALTH PROBLEM

In the discussion of "The General Practitioner in a Public Health Program," it is fundamental to understand the answer to the question, "When does a health problem become a public health problem?" This can be tossed about at great length with a play on words, such as, "What do we mean by public?" and "What is our definition of health?" There are, naturally, extreme points of view.

Mustard[2] states that "the general trend is to consider that a health problem becomes a public health one, when, because of its nature or extent, it may be solved only by systematized social action."

The control of communicable diseases is a good example where, for the protection of the public, government must restrict the movement of an individual for the protection of the majority. The provision of a safe public water system and proper sewage disposal are public health problems requiring coordinated community action for effective solution. Health education and the registration and analysis of vital statistics fulfill the above concept of a public health problem. Case-finding of tuberculosis may well be the function of a public health physician, but the final diagnosis and clinical management are the sole responsibility of the clinician.

Mustard[2] has this to say about the sick individual: "It is in relation to problems of the sick individual that questions arise as to the extent to which organized society, through government, should take action. One wealthy individual with diabetes, or a thousand pregnant women able to pay their way, do not necessitate any organized action for their care, and their problems would not therefore fall within the limits of the concept of a public health problem as set forth above. But a hundred diabetics uneducated as to care of their feet, unable to buy insulin or to pay a physician, or a thousand maternity cases with no funds for medical care would necessitate organized action, whether by hospitals, by health departments, or by a privately-operated clinic. The real question at issue, then, is not so much whether the person is well or ill, or even, in the last analysis, whether rich or poor—for the rich use the sewerage system, but rather when, or if, a given problem of health and disease can no longer be solved by the unassisted effort of the citizen and the uncoordinated resources of the community."

A famous cancer specialist says, "The fate of the cancer patient is in the hands of the first physician who sees the patient." This physician, in the vast majority of cases, is the general practitioner. Similarly, he sees, first, those diseases which are of public health significance, and therefore has the best opportunity to practice preventive medicine. Logically, then, the effective application of sound and scientific principles of preventive medicine to all the people of our state falls upon the general practitioner.

REFERRAL OF THE PUBLIC THROUGH HEALTH EDUCATION

Definite assurance can be given that the public health physician does not want to treat disease. Neither does he want to attract patients from the private physician to the public clinic. On the contrary, the health officer and his staff guide individuals to their family physician. Parents are urged to have their children immunized and to take them to their own physician. The importance of early prenatal care is emphasized again and

* State Health Commissioner, Indiana State Board of Health, Indianapolis, Indiana.

[1] In Resolution from Section on Preventive and Industrial Medicine and Public Health on Civilian Health Protection in War. *J.A.M.A.*, June, 1942.

[2] Mustard, Harry S.: *Government in Public Health*, New York, The Commonwealth Fund, 1945.

again with the suggestion that expectant mothers consult their physicians early in pregnancy. The physical examination of teachers and food-handlers is done by the general practitioner. Individuals with a positive tuberculin or a doubtful or positive photofluorographic film are referred to their family physician for diagnosis and treatment. Children found to have doubtful or positive physical defects through school examinations are referred to their physicians. The above referrals and many others occur during the routine duties of health officers and nurses, in addition to the information given to countless individuals, civic clubs, schools, and other organizations through talks, movies, pamphlets, and other educational media.

Many patients, then, are led to the general practitioner's office by the State Board of Health and by well-organized local health departments. The physician, on his part, has an obligation to practice preventive medicine. What are some of the specific opportunities he has in this field?

COMMUNICABLE DISEASE CONTROL

Medical science has provided us with preventive methods for controlling several of the more common communicable diseases—smallpox, diphtheria, and pertussis. We have had a specific agent for the prevention of smallpox since 1796, when Jenner performed his human experiments. Smallpox has been almost eliminated in this country, but, unfortunately, Indiana's record does not bear too close scrutiny. A bulletin of an insurance company[3] has this to say about smallpox in Indiana: "Although remarkable progress has been made in suppressing smallpox in our country, there were still some disquieting elements in the situation even before the recent outbreak. Some states year after year continue to serve as the main reservoir of smallpox infection. Indiana, for example, for three successive years has had the largest number of cases in the country. The fifty cases recorded by this state in 1945 were about one-seventh of the national total. That this unenviable record is due not to the spread of infection from neighboring states but to conditions within Indiana may be deduced from an examination of the smallpox records of the four adjoining states—Michigan, Ohio, Kentucky, and Illinois. Although not among the most advanced in the reduction, the four states together had fewer cases than did Indiana alone (forty-two as against fifty), despite the fact that their total population was six and one-half times that of Indiana. The case rate for the four bordering states combined was less than two per million population, whereas Indiana's was 14.5 per million."

Diphtheria still strikes too many youngsters and causes too many deaths. During the five-year period 1941 to 1945, 1,958 cases were reported and 146 deaths occurred. Our diphtheria mortality rate is one of the highest in the North-Central group of states. As an example, if we had the diphtheria mortality rate of Wisconsin, only three persons would have died last year from diphtheria instead of the thirty-three reported.

Whooping cough causes twice as many deaths in children under five years of age as measles and diphtheria combined. Pertussis vaccine is an effective agent for preventing the disease in some, attenuating it in others. The answer to the control of these preventable diseases is early immunization, beginning at six months of age with completion at one year.

AN IMMUNIZATION SCHEDULE

A schedule very generally used is as follows: vaccinate against smallpox within the child's first six months of life. When he becomes six months old, immunize him against whooping cough. At nine months, he can be given a series of combined diphtheria-tetanus injections. At six years of age—just before he enters school—revaccinate against smallpox and add a booster injection of diphtheria-tetanus toxoid.

Ideally immunizations should be done in the physician's office. This has been found ineffective in many communities as measured by the number of susceptible children immunized. The physicians and the health officer, with their intimate knowledge of local conditions and needs, are the ones to determine the procedure to be employed. They will wish to weigh the advantages and disadvantages of the various methods in relation to the desirability of a well-protected population versus one poorly protected.

Persuading the mother to bring her child to the physician's office is one way in which the local health department, and particularly public health nurses, can assist. It may be a little difficult, and certainly time-consuming, for the physician to urge these early immunizations. This is one of the major activities of your local health department. One health officer in Indiana sends a reminder to parents when the child is six months of age, and again at one year, stressing the importance of immunization and strongly urging them to take their youngster to the family physician.

With a harmonious and effective relationship between the physician and the health officer and his staff, the need for special clinics for medically indigent or mass school clinics will be minimized. When these are deemed desirable the program should be developed in agreement with the local medical society.

Certain other diseases, such as scarlet fever and measles, can be more easily controlled and their spread minimized if these cases are reported at once to the health department so proper isolation of the patient and examination of contacts can be done. The Indiana State Board of Health supplied 25,000 cubic centimeters of serum immune globulin to the physicians throughout the state for the prevention and treatment of measles last winter. Approximately 40,000 cubic centimeters of

[3] Smallpox at Its Lowest Ebb in 1945, *Statistical Bulletin*, Metropolitan Life Insurance Company, (May) 1946.

blood plasma obtained through the American Red Cross were made available upon request to the hospitals of the state for use by local physicians.

CASE-FINDING IN TUBERCULOSIS CONTROL

The health department can and does assist in early case-finding of tuberculosis, but the diagnosis and management of the case belong to the clinician. Here again the family physician usually sees the case first, so upon him falls the responsibility for early diagnosis. Approximately 85 per cent of the cases in sanitariums are in a moderately or far-advanced stage. Our biggest obstacle in tuberculosis eradication is to find the case early and institute proper isolation and treatment in order that an early cure may be effected and exposure of other individuals be reduced. A screening process for adults, using 35 mm. or 70 mm. photofluorographic equipment, has been demonstrated to be an efficient and economical method for early case-finding. Large groups of adults can be screened in a relatively short time. It cannot be emphasized too strongly that this is only a screening procedure. The reports of doubtful or positive cases are sent only to the physicians designated by the individuals. The patients are informed only that there is some question concerning their chest film and are urged to consult their physician, to whom the report has been sent. The public health nurse will check with the physician, within a reasonable period of time, to ascertain if the patient has reported for examination. If not, the nurse will visit the individual and attempt to persuade him to see his physician.

There is no better demonstration of the integration of preventive and clinical medicine than in the procedure briefly described above. This is an example of modern medical science being effectively applied by the general practitioner with the assistance of the local health department.

VENEREAL DISEASES

The problems here parallel, in many respects, tuberculosis control. The objectives are early case-finding, institution of proper treatment, and finding of contacts from whom the patient may have contracted the infection or to whom he may have given it.

A few individuals with gonorrhea or syphilis go directly to the specialist, but by far the vast majority go to their own physician, the general practitioner. There is an added responsibility over and above the diagnosis and treatment of the patient. This patient has a contagious disease. It is desirable for the health of the community to find the source of this infection so that he may be placed under treatment by his physician, thereby eliminating one focus of a communicable disease. The family physician, because of his rapport with the patient, can secure data concerning contacts or sources of infection. In some instances the patient can be persuaded to secure the examination of contacts; in others, the physician may have considerable success through correspondence. When the above methods fail, it then becomes the responsibility of the local health department to find the sources and contacts of this patient with a communicable disease and see that these are referred to a physician for examination and treatment, if necessary. In this example the physician has a responsibility to his private patient, but because this patient has a contagious disease the physician has an added responsibility to the community for prompt reporting of the case and the names of those contacts whom he has been unable to locate.

HEALTH EDUCATION

The general practitioner sees illness every day; he enters many homes each day during his calls; and he performs periodic physicial examinations. During these activities he has the greatest opportunity of anyone to contribute to the health of the family, and through them to the community's health. The physician has not functioned completely in this capacity until he has assumed these public health responsibilities. He limits his attention to the sick individual. Part of this has been due to lack of time—so many patients and so little time, and, during the war years, so few physicians. The matter of ethics acts as a deterrant, too. If the physician inquires concerning the health of other members of the family—why the mother hasn't been in for a post-natal check, and why the baby hasn't been immunized—the family might feel that the physicians was attempting to secure additional patients.

Mindful of the past and present experiences and the reasons for them, if the physician could take time to interest himself and function for the whole family, sick or well, the community's health would be improved materially. As it is now, the public health nurse has, to a large degree, taken over this potential function of medical practice.[4]

A speaker at the Secretary's Conference of the Indiana State Medical Association last winter urged local societies to assume a more active role in the education of the public in their communities. His appeal, if recalled correctly, was for the organized profession to concern themselves with medical problems outside the care and treatment of the sick in their offices, so that they might assume the leadership, which is rightfully theirs by training, experience, and hard work, in problems involving the practice of medicine rather than allow inexperienced and sometimes misguided individuals and groups to establish a new and undesirable pattern.

One method of assuming this rightful leadership is in acquainting the people of the community concerning their particular health problems, the miracles of medical science for preventing certain diseases, newer knowledge concerning cancer, diabetes, the necessity for early prenatal care, and facts about diseases of the heart and circulatory system. The Indiana State Board of Health has

[4] Richardson, Henry B.: *Patients Have Families*, New York, The Commonwealth Fund, 1945.

statistical data concerning the morbidity and mortality of diseases for all communities and could furnish this to the local physicians for their presentation to their own community. This can be done through the local newspapers, sponsored by the local society, or in presentations to various civic organizations by designated members of the society.

Both the Indiana State Medical Association and the American Medical Association have stressed the need for local health departments manned by full-time, well-qualified personnel, under the direction of a full-time physician, and have urged communities to establish such units. Indiana has only three full-time health officers in the entire state. We have 175 part-time health officers. The lack of such organized units provides the major reason for Indiana's poor rating in public health, as compared with our neighboring states.

A COUNTY MEDICAL SOCIETY SPONSORS A FULL-TIME LOCAL HEALTH DEPARTMENT

One county medical society in Indiana has undertaken the task of acquainting its county with its public health needs and is actively sponsoring and working for a full-time local health department. This society is not only assuming the progressive leadership expected of them by the community, but is also acquiring the further good will of the people of this county to them as individuals and to the organized profession. The Indiana State Board of Health, upon the request of this society, has furnished assistance of various types to this medical society, in this very worth-while project, and would like to have other local societies adopt similar programs.

NECESSITY FOR UNDERSTANDING AND CONFIDENCE

One final point merits consideration. This concerns the absolute necessity of understanding and confidence between the general practitioner of medicine and the health officer, who might be called the general practitioner of public health. There have been instances in which each have been quick to criticize the other. This should not occur, for it reacts unfavorably upon both. There is fairly general agreement upon the major objectives of a public health program, but the methods of accomplishing these may create justifiable and understandable differences of opinion. It would appear more logical, and surely more helpful, if these differences could be discussed frankly, impartially, and without prejudice by those concerned, and every effort made to secure a satisfactory solution equitable to all concerned. There must be mutual confidence and respect between the physician and the health officer or the best of our efforts will be to little avail.

Our biggest task in Indiana is to establish and maintain the basic elements of a sound public health program available to all the people of the state, and not to concern ourselves with new and untried programs for which we are not ready and which scientific or other facts do not justify.

THE INDIVIDUAL'S RESPONSIBILITY

One very essential point is too often lost sight of; namely, the individual must do something for himself. He cannot have everything done for him. One of our troubles today may be that too many people believe that the "world owes them a living." Self-reliance is a virtue to be sought, earned, and of which to be proud. Too little of this virtue weakens the very keystone of our strength and our ability to progress.

Medical science can perfect miracles for the prevention and treatment of disease; the physician and the health officer can enlighten the people as to their problems and their needs, and can also supply the skill and experience necessary to fulfill these needs; but, in the final analysis, the individual, as the unit of society, must assume some interest, some initiative, and some responsibility in improving his own health. Neither the physician, the health officer, nor the government can do the job alone.

CONCLUSION

Many factors affect the community's health, such as research, education, economic status, housing, availability of hospitals, and good environmental sanitation. Greatest dependence, however, must be placed upon the individual's health, because he is a member of a family, and that family is a unit in a community. The general practitioner—the family physician—has the direct responsibility for the care and treatment of the sick individual, the practice of curative medicine. It is hoped that time and opportunity in the future will enable him to assume equal prominence in the field of preventive medicine. As a counselor to the whole family, as a means of sound and scientific health education, as an authoritative force for the application of modern medical science for the prevention and cure of disease, the general practitioner has no equal and no competitor. Working together with an appreciation of each other's spheres of responsibility and usefulness, the general practitioner and the full-time health officer can fulfill their obligations to the people of our state.

Excellent programs are in store for you at the scientific sessions to be held in connection with the annual session of the Indiana State Medical Association, October thirtieth. You can not afford to miss them.

TREATMENT OF PEPTIC ULCER IN THE DIABETIC

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ELKHART

The average physician is entirely capable of managing the patient with an active peptic ulcer. Likewise, he has good results in controlling the average case of diabetes. When he encounters the diabetic patient with a complicating peptic ulcer he frequently becomes confused as to what he should do or should not do in the treatment of both these conditions. Fortunately, only a small percentage of diabetics are likely to develop peptic ulcer.

Basically, the treatment of peptic ulcer in the diabetic patient is very much the same as the treatment in the non-diabetic patient, with the exception that the underlying diabetes must be kept under good control by adequate management of diet and insulin dosage.

In the case of the diabetic who has been in good balance it is likely that the activation of the ulcer will precipitate the need for increased insulin dosage. This can be determined by frequent blood sugar determinations, and the insulin dosage can be regulated accordingly.

The ulcer condition itself is treated primarily by the method ordinarily used and preferred by the attending physician.

Personally, I prefer and have had good results with the ambulatory method, employing frequent between-meal feedings of a milk and cream mixture, as outlined by Dr. Walter C. Alvarez.[1]

The only adaptation required for such treatment to suit it to the diabetic is the need for measuring or preferably weighing the food intake and calculating the carbohydrate, protein, and fat ingested to provide an adequate caloric intake to maintain the control of the diabetes. Usually the allowance of 2,200 to 2,500 calories per day, depending upon the patient's occupation and his activity, is adequate. I usually allow four ounces of a mixture of equal parts of whole milk and 20 per cent coffee cream at 10:00 A.M., and 2:00, 4:00, and 8:00 and 10:00 P.M. The patient eats breakfast at 8:00 A.M.; lunch at 12:00, Noon; and supper at 6:00 P.M.

The above five interval feedings will provide 27 Gm. carbohydrate; 19 Gm. protein; and 69 Gm. fat. These amounts are subtracted from the total daily diet quotation and the remainder is then divided into either three equal or unequal portions, depending upon the dietary need of the patient to maintain his proper diabetic balance. The foods for these meals are chosen from a smooth diet list such as is to be found in any book on diets. Custards are prepared according to diabetic recipes without sugar. Fruits are likewise prepared without additional sugar, saccharin being used to sweeten as desired. For example, a diet of carbohydrate, 175 Gm.; protein, 100 Gm.; and fat, 130 Gm., provides 2,270 calories. The daily diet would appear as below.

Breakfast	Gms.	*CHO* *48.3*	*Prot.* *27.3*	*Fat* *20.3*
Strained orange juice	45	4.5		
Cream of wheat	80	17.6	2.4	
Bread (toasted)	40	21.3	5.3	
Bacon (crisp)	12		4.5	6.0
Eggs (poached)	2		12.0	12.0
Milk (skimmed)	100	5.0	3.0	
Butter	3			2.4
Total		48.4	27.2	20.4
10:00 A.M.				
Milk and cream mixture	120	6.0	3.6	13.8
Lunch		48.3	27.3	20.3
Chicken	60		15.6	6.0
Potato (bkd. or mash.)	65	13.0	1.3	
Asparagus (pureed) or spinach or green beans	80	2.4	0.8	
Bread	30	16.0	4.0	
Butter	8			6.4
Milk (whole)	200	10.0	6.0	8.0
Puree, peach or pear	100	7.0		
Total		48.4	27.7	20.4
2:00 P.M.				
Milk and cream	120	6.0	3.6	13.8
4:00 P.M.				
Milk and cream	120	6.0	3.6	13.8
Supper		48.3	27.3	20.3
Cottage cheese	50	2.0	10.0	0.5
Bacon (crisp)	12		4.5	6.0
Carrots (pureed)	80	4.8	1.6	
Bread	30	16.0	4.0	
Milk (whole)	200	10.0	6.0	8.0
Butter	7			5.6
Banana (ripe)	75	15.0		
Total		47.8	26.1	20.1
8:00 P.M.				
Milk and cream	120	6.0	3.6	13.8
10:00 P.M				
Milk and cream	120	6.0	3.6	13.8
Daily food intake		174.6	99.0	129.9

[1] Alvarez, Walter C.: Peptic Ulcer (Ambulatory Treatment with Frequent Feedings) *Beckman's Treatment*, Second Edition, pp. 419-420, W. B. Saunders Co., Philadelphia, Pa., 1934.

Many diabetics already are familiar with the calculation of their own diets, the advantage being that by referring to their food-composition charts they are able to get a more nearly normal variety of food; hence, they have less temptation to cheat. The average intelligent diabetic or a member of his family can be taught to calculate these diets in one-half to one hour's instruction.

Other meats may be substituted as well as other cereals, fruits, and vegetables compatible with the smooth diet list. The patient can follow such a regimé over a long period of time. We, of course, know that all ulcers cannot be treated indefinitely by dietary means alone, as sooner or later a certain number will either perforate or bleed and surgery is needed. Such cases are emergencies, and the diabetes must be controlled in the hospital in line with the treatment indicated for the emergency condition.

I have been called upon to manage two active ulcer cases occurring in diabetics within the past few months. Both are working at their usual occupation, the one driving a small truck in a factory; the other doing heavy work in a foundry. Both are doing well at present; the one without antiacid powders; the other with a simple antiacid powder. When it is needed, one can use one of the simple antiacid preparations without much danger of upsetting the diabetic balance.

As to the insulin to use in such cases, I would say, "Use the insulins the patient is already taking." Much depends upon the individual physician. Whatever regimé of insulins or combinations of modified insulins you use, be certain that you fully understand their mode of action so that you and the patient know what to expect from them in the way of reaction. A severe insulin reaction might do great harm to a diabetic with a peptic ulcer.

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THE OFFICE PRACTICE OF THE GENERAL PRACTITIONER

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NEW ALBANY

Permit me to explain that the only reason I am writing this article is because Dr. Jacob T. Oliphant, chairman of the Section on the General Practice of Medicine, asked me to do so, and anyone who really knows Doctor Oliphant will do most anything for "Jake."

In further explanation, I quote parts of his letter to show that he not only selected my subject and told me what to write, but also explained why he had selected me to write it. I quote, "One topic well worth writing about is 'The Office Practice of the General Practitioner.' This could be broadened to include the equipment, the type of procedures which may be undertaken, the kind of office help required, and everything else that pertains to the office of a successful general practioner. It should be a general discussion that will encourage the men in the county seat towns and smaller villages to do better work—so I am asking you to write it." (End of quotation—photostatic copies supplied on request.)

I can definitely qualify as being one of the county seat boys of Floyd County, for more than a half century, and I have "doctored" in the village of New Albany, in the hills of southern Indiana, for thirty-five years. I profess no further qualifications, but perhaps someone may benefit from my observations and mistakes through the years.

In order to have a successful office practice, you must first have an office. The modern doctor's office need not be pretentious or elaborate, but it must be clean; second, it must be comfortable; third, it must be cheerful; and fourth, it must be practical, orderly, and efficiently arranged. It can consist of two rooms or a suite of ten rooms. There was a time when some doctors dumped a ton of coal or a cord of wood behind the stove in their waiting room; piled their pills and plasters, dressings, rags, and instruments on a dusty table, or stuffed everything into the dusty pigeonholes of a roll-top desk. There are still a few of those doctors left, sitting in their self-made bacteria incubators waiting for patients who seldom come.

There should be comfortable chairs in the waiting room, a few pleasing pictures on the wall, fresh magazines on the table (this year's at least), convenient ash trays, and a practical rack for patients' hats and coats. One or two small chairs and a few unbreakable trinkets for the kiddies make a big hit with mothers as well as the small fry. Regardless of how simple or expensive your office furnishings may be, your outer room can have the dignified appearance of a professional office and need not resemble a gloomy bus station, a gilded beauty salon, or a gay ninety parlor.

First impressions are very convincing and often become lasting images. The first impression a new patient gets of the doctor is the result of study of your reception room during a one- to three-hour wait. The second impression he gets is of the office receptionist or attendant during that wait. The physician comes third on the list, and if the first two are not pleasing and favorably impressive, we, as doctors, run a poor third and are sometimes scratched. I am telling these little things because

in most of the offices today improvements could be made.

Now, in this office there must be a doctor. He, too, should be clean. He should look like a doctor, for he is already third on the impression list. Thank the Lord, Hart Schaffner & Marx, and *Esquire*, the days of Prince Albert coats, starched fronts, and "zitz" whiskers are gone, but I'm still old-fogy enough to believe that a doctor should wear a collar and tie and not greet his patients with a tee shirt or a turtle-neck sweater; and whenever I see one of our modern doctors on professional duty in one of those newfangled slack suits with his shirt tail out, I am not surprised that supposedly-intelligent people go to respectably-dressed chiropractors.

I know that "clothes don't make the man," that "this is a free country," that "we can wear what we please," that "we must be comfortable to work," that "we just can't stand the heat," that "we usually play golf, go out to the farm, or work in the garden after office hours," and I know all the other often-repeated excuses for looking sloppy. Confidentially, my favorite leisure garb consists of a pair of shorts and no shirt at all, so I guess I'll go on sweating it out with a collar and tie, because it feels so good when I take them off.

Next on Doctor Oliphant's request list is the "kind of office help." There are not enough pages in THE JOURNAL to properly cover this one phase of the doctor's office, so I must limit my discussion to a few of the cardinal points:

Qualifications—She, too, must be clean, neat in dress, and conservative in habits, pleasant but not frivolous or gushing, kind and sympathetic but not melodramatic, alert but not jittery, friendly but not fresh, intelligent but not high-brow, pleasing in appearance and personality but not too glamorous. She must have appeal without "oomph" and, most important of all, she must have ears that hear all, and a curb bit on her tongue connecting with her brain.

To find one or more office attendants with these qualifications is no easy job. We cannot all employ graduate nurses for our offices. The field is limited and many nurses well qualified for hospital or bedside duty do not make good office assistants, so we are usually called on to conduct our own training school for office attendants. If unable to secure a graduate nurse, medical technician, or an assistant with previous experience, select a widow under forty or a girl who has passed the boy-crazy age and has no hope chest. She should come from a substantial family with some social background. High school graduation and stenographic training is essential. A year or two in college makes her even better. Corporation stenographers and factory workers seldom make good physicians' assistants. They are usually clock-watchers and are mainly interested in what you pay. A good assistant in a doctor's office must love her job, be loyal to her employer, and sacrificing in devotion to her chosen career.

Her duties are a thousandfold. She greets your patients, answers your telephone, keeps your books, banks your money, pays your bills, buys your supplies, gives shots and applies minor dressings, assists with treatments and office surgery, takes case histories, files your records, writes your letters, books your appointments, and does your routine laboratory tests.

She sends your laundry, clears your desk, keeps your tax records, figures your diets, maneuvers you out of the office on golf days, and does a million other things that you do not realize and seldom appreciate. She can handle anything that comes to your office from an irate patient or a persistent book agent to a dangerous blonde. She is your right hand, your ambassador of good will, and conciliator of ill will. It takes several years to produce such an assistant, and the longer you have her, the more helpless you become without her. For that reason I usually carry a "spare." A capable office assistant is your best-paying investment and the most essential feature in your office. Definitely, such a person is entitled to good pay, considerate appreciation, and free theelin as and when needed. Caution: Do not hire relatives, daughters or sisters of friends or patients, or your "girl friend." It just does not work.

Well, I am finally taking you back into the consultation room, the "sanctum sanctorum" of the doctor.

It, too, must be clean, just like the doctor, the nurse, and the reception room. It is fourth on the impression list. It must be neat, orderly, and not crowded. In accordance with your needs, it can be a combined consultation and treatment room, or a consultation room with one or more treatment rooms adjoining. In either setup the essential equipment includes a desk, chairs for yourself and the patient, a table for examination and treatment, files for your records, cases or shelves for your medical library, a sterilizer and cases for your instruments and supplies, and, by all means, a place where your patient can undress in privacy.

As regards special equipment or a modality, do not buy it unless you have frequent use for it, plenty of space to put it in, and someone capable of operating it. Buying a piece of expensive, special equipment and crowding it against the wall behind other furniture is like putting money into a rat hole, and that is where you find most of the special equipment of the average doctor's office. If you dispense instead of prescribe, you should have a special room or alcove for your pharmaceutical supplies, and you do not make a good impression on your patient by doing a urinalaysis in your consultation room.

Diathermy, basal metabolors, the various therapeutic lamps, galvanic, sinusoidal and other electric current generators are among the more valuable treatment and diagnostic aids in the modern armamentarium of the general practitioner, but he is wasting valuable time on these things

unless he has capable assistants to do the operating under his direction.

Roentgenology, electrocardiology, allergy skin testing, eye, ear, nose and throat and other special surgery, and the more complicated laboratory procedures have no place in the average general practitioner's office, but should be left to the specialist unless the general practitioner has had special training on the subject and has graduate technicians in his office. (Special training does not mean a ward-walk while on vacation or a convention instructional course.)

I recognize that in many small or rural communities where there are no hospital or specialist facilities the general practitioner is called on and is expected to do everything, and he is to be commended for the valuable service he renders his community. These men are usually conservative in their procedures, and tread cautiously into unknown fields. Their special equipment is a community necessity and they do not make many mistakes in the use of it.

I do not mean that a general practitioner should not have an x-ray unit or an electrocardiograph in his office if he wants it and knows how to use it. A small or portable x-ray unit is a valuable assistance to a busy general practitioner providing he limits its field and does not try to do everything with it. A large x-ray is not a sound investment for the general practitioner. If your x-ray equipment is not shock-proof, sell it tomorrow or treble your liability insurance today.

Back in the horse-and-buggy days and in the era of the saddle-bags, the general practitioner or family physician spent most of his time traveling the country road, treating typhoid, malaria, dumb ague, pneumonia, smallpox, "membranous croup," rheumatism, "inflammation of the bowels," dysentery, lacerations, "blood poisoning," and "baby cases." Today preventive medicine, modern medical and surgical treatment, hygiene, sanitation, and improved living conditions have practically eradicated or greatly modified the severity and frequency of these illnesses.

The maternity cases have been moved into the hospitals, and the doctor can now devote most of his time to office or hospital practice. It is said that some men prefer blondes and others brunettes; likewise some physicians prefer house visits while others prefer office or hospital practice. We are usually most successful and more capable when doing the things we like best.

There is a vast and bountiful field of endeavor for the general practitioner who prefers to do office practice. He need not encroach on the specialties or tread into unknown lands.

In addition to the usual run of ambulatory patients and those with functional disturbances that find their way to the physician's office, there are now hundreds of important pathological conditions being treated successfully in the general practitioner's office, patients who formerly went to the specialist or a metropolitan clinic. Improved standards in medical education and the remarkable new developments in pharmaceutical chemistry, organotherapy, biologic therapy and prophylaxis, and electrotherapeutics have played an important part in widening the beaten path to the doctor's door. The radio, frequent medical and health discussions in lay magazines, and various disease-control and prevention campaigns have made the public health-conscious, and they now demand periodic physical examinations. The representative of one of the leading pharmaceutical houses recently told me that following the publication of an exaggerated report on the merits of testosterone, in one of the lay magazines, the demand was so great that the distributing houses were forced to ration the product.

The public no longer fears the needle. Parenteral treatment is in vogue. It is definitely more rapid in action and more effective therapeutically. Most patients now understand that if you give them "shots" they will get well quicker. The successful general practitioner now has a battery of sterile syringes and needles on hand at all times and many different kinds of ampules in his wall case and refrigerator.

Office or medical gynecology is a vast but neglected field of the general practitioner. Much of the gynecological surgery performed today is due to the family physician's failure to make vaginal examinations and treat the condition in its incipiency.

Yesterday Mrs. S. was having pain on voiding. Did you examine, find, and treat a fiery-looking caruncle or just prescribe some pills for her cystitis? Trichomonas vaginalis runs wild and sets 'em wild while physicians prescribe some sweet-smelling douche powders that feed and fatten the tormenting imps. There is a neglected and eroded cervix in your clientele which will be a carcinoma by and by. I mention these common everyday conditions to illustrate that you cannot get the whole picture by just looking at the tongue.

In recent years endocrinology has progressed so rapidly that publications on the subject are out-of-date before they come off the press, but there are many physicians who still think that endocrinology means a newfangled treatment for "change of life." Well it does, but not just the common meaning, referring to the female climacterium. Diseases and functional disturbances of the endocrine glands actually change the lives and development of mankind. A great part of the chronic cases which frequent the doctor's offices are due to or influenced by endocrine abnormalities.

Fröhlich's and Cushing's syndromes frequently sit side by side in the general practitioner's office, but usually come in and go out incognito. A composite picture of the average doctor's office would include a cute little fat girl; a sweet-faced boy; an emaciated woman who looks like an unwrapped mummy; a big, soft hunk of a man, resembling a dead fish; a chatter-box lady; a bald-headed, pot-bellied business man with bags under his eyes and a droopy jowl, a jittery woman with bulging eye-

balls, and a precocious little brat resembling Red Skelton's "mean little kid." We have seen this composite picture in our own waiting rooms many times, but do we recognize them as possible endocrinopathies? These cases are definitely the responsibility of the general practitioner. They never go directly to the specialist, and usually only when it is too late. There is much to be done and that can be done in this field. I do not mean that the general practitioner should be able to diagnose and treat all the endocrine abnormalities.

Some of these cases will respond to proper office treatment, but many of them should be referred at once to the surgeon, roentgenologist, endocrinologist, or neurologist. Barnum and Bailey's sideshow of freaks is a scientific exhibit of cases the family doctor muffed.

Many of the common conditions found in patients that come to the physician's office are often the direct or secondary result of endocrine disturbances. Obesity, emaciation, adynamia, headache, vertigo, hyper- and hypo-tension, albuminuria, glycosuria, polyuria, aneuria, hyperhidrosis, anhidrosis, cardiac, vascular, and gastro-intestinal abnormalities are often of endocrine origin, as well as the many sex, growth, and neurological disturbances. You can spot most of these cases if you are a close observer of the patient's facial expression, build, posture, contours, gait, and personality, although you may not be able to make a differential diagnosis.

It is a big and fascinating study warranting more attention by the general practitioner, and in closing this glandular paragraph, may I suggest that the tired business man in your office may be having "change of life."

Well, if you do not care for parenteral treatments, medical gynecology, or endocrinology and are still looking for something to do in your office, you can put in a fountain cuspidor, some compressed air and some DeVilbisses and spray some noses and swab some throats. Be sure to charge for it or they will ask for it every time they come in.

There are also a lot of common and industrial skin diseases that can be treated in the general practitioner's office. Most of these get well anyway, or they go to someone else. I have a personal letter from the director of the dermatology section of one of the great American clinics, which says: "The treatment of skin diseases is mainly a question of trial and error." I asked a leading skin specialist in Louisville what to do in a certain case, and he replied, "Your guess is as good as mine." So start plastering with your black, white, or pink tar and paint with your calamine or phenol lotion and you may make a reputation for yourself, especially if you use that quartz lamp you paid so much for and never made a dime off of.

You might also get out that fulguration unit that you bought at the convention and fry some warts and moles, but be sure that you know your moles.

I could continue this rambling concerning the treatment and consultation room and find lots more for you to do. Most practitioners have too much to do or try to do too much. It is a wise doctor who recognizes his own limitations and ability and who does not try to do everything. There was a time back in the Prince Albert days when some physicians hoodwinked and impressed the public with their self-acclaimed ability to do everything. They were not the great pioneers of American Medicine, but the charlatans of yesterday.

Today there are few charlatans left, but we do have a few men in some communities who are constantly in a dither or a daze for fear a dollar will get away. They have forgotten the Oath of Hippocrates, which they solemnly repeated on the night of their graduation, and which said in part, "I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners (specialists in this art.)" They seldom refer a case and consider a request for consultation an insult to their self-glorified ability. They consider their fellow physicians as commercial competitors and not as professional colleagues. They know nothing of the thrill of having a diagnosis confirmed in a higher court of medical knowledge, and they seldom profit by their own mistakes.

To have and to hold a successful office practice, the general practitioner must constantly study and use the new and proved methods of treatment. He must devote adequate time to each patient and expect to work long hours in his office. A completely-written case history and a thorough physical examination is absolutely essential. He should inspire confidence by his frankness and honesty. He should never make a snap diagnosis or bluff an opinion. If he is unable to make a logical diagnosis, he should frankly tell the patient that he wishes to give the case further study. We might all take a lesson from the attorneys who seldom make a statement or render an opinion without looking in a book.

The general practitioner should frequently associate with and consult medical authorities in special fields, and should make use of modern laboratory procedures in his diagnostic studies. He should welcome and often suggest consultation before it is requested. He should be charitable to the deserving poor and make charges in accordance with the patient's ability to pay. He should be a substantial contributor of time and money to the best interests and welfare of the community, but should assume a conservative role and avoid controversial issues and the mal-contents. He should be tolerant and never too opinionated. Last, but not least, he should be humble.

In conclusion, may I suggest that we occasionally read the Oath of Hippocrates, which hangs on our wall, and remember that "Abe Martin" once said, "Bill Spiven had a cow that broke its neck reaching over the fence for green grass in the neighboring pasture."

FAMILY PHYSICIAN—A REMINISCENCE

JAMES B. MAPLE, M.D.

SULLIVAN

My experience as a general practitioner covers about forty-five years, and includes a period wherein we were known as the family physician, general practitioner, plain and internist, and now we seek to become known as "General Practitioner, Specialist." At the beginning of this century most of us were better known by the term "country doctor," for we spent most of our time riding the countryside. In the winter we traveled afoot and on horseback, and sometimes in a cart. Our buggies were for the few better roads, and they were few. In the summertime it was too hot to drive your horse fast, so you just jogged along, and you were too warm for comfort.

The practical side of our education was almost nil, and experience and necessity became your real teachers. If you wanted an enema given, you gave it yourself. If the patient needed special nursing, you stayed all night, or all week as need be, and gave it yourself that your patient might survive. Hospitals were distant, and few patients could be persuaded to go to them. Nurses were unheard of except in hospitals and cities. Laboratory procedures consisted mainly of urinalysis, and an occasional practitioner could make a blood count or analyze a test meal.

Pharmaceutical houses were few, and the drug salesmen were limited to one or two houses. Detail men had yet to be invented. Drugs used were also few: quinine, bismuth, acetanilid, alkaline digestive, chloroform and ipecac or squill cough syrups, yellow root, chloral, corrective cordial, rhubarb, salts, caster oil, morphine, tincture of opium, and paregoric. Quinine, yellow root, bismuth and acetanilid, in varying combinations, were the sheet anchor in most cases, even as A.S.A., sulfa, and penicillin are today.

Medical men were located about five miles apart in every direction, since five miles was about the maximum distance one could practice with a horse and buggy. At that time there were fifty-two medical men in practice in this county, whereas today we have only twelve active practitioners. In that day one scarcely needed an office except as a place for the messenger, who had been sent for him, to wait until the physician drove in from the call he happened to be making. Offices were poorly furnished and for the most part poorly kept. A few men had what were adequate quarters for that day, and kept them in good condition. The rest of us had not yet learned the lesson of cleanliness, and our patients often mistook our stoves for cuspidors.

Our medical libraries consisted chiefly of our school text books, with an occasional new book and hand-me-downs from some older doctor's office. One depended upon his own ingenuity and used whatever he found at hand. Hot and cold water, coffee, tea, wine, whiskey, bread and milk poultices, white oak-bark tea for edema, tansy tea for delayed menses, boards from the scrap lumber pile or barn for splints, flux weed for dysentery, and I have seen a common housefly used as a very successful emetic.

Obstetrics, as practiced, was a case of hopeful expectancy, with the physician often staying hours, and even days, waiting for nature to take its course. When nature failed to produce, forceps were a matter for consultation, and were a major procedure. Repair of lacerations was seldom done. How often, when the job was done, all the physician received for his trouble was a backache, from working over a folding-bed and a feather mattress.

Babies were the victims of our ignorance of proper feeding and hygiene. Dysentery was rampant all summer long, chiefly because we had not yet learned the danger that buzzed about with the common housefly. I once saw thirty-two funerals of babies under two years of age during the single month of July, caused by "summer complaint" as it was called in that day.

Typhoid fever was one of the most common diseases. It was thought to be a water-borne infection, but with the coming of wire screens and their universal use, together with the "swat the fly" campaigns, it has become a rather rare disease. Pneumonia was with us all through the winter months, and many were the weary nights we spent watching the patient through the crisis. If the patient died, God's will be done, but if he lived the physician was credited with pulling his patient through. How we had to fight to get a window open for the oxygen needed, and what explaining it took to get visitors and relatives out of the sick room so they would not utilize that precious fresh air. Sometimes it almost took force, and window lights on occasion had to be kicked out to keep grandma from shutting up the room and making it airtight.

The young physician who started out in the early days of this century had a long, hard road ahead of him. In those days it was the older physician to whom the people turned, for he had had experience. It is much different now; people go to the young physician, hoping he has brought with him the latest method, drug, technique, or knowledge, which somehow the older man has failed to secure because he has not put forth the effort to keep up-to-date.

I have been a general practitioner for forty-five years, and they have been good years. I have been a friend of the family. To my consultation room has come the good and the bad of life, but I am not the judge; human nature is to be taken

as is. The husband admits to me what he will not tell his wife, and the wife tells me the things that trouble her. The children grow up to tell me about father and mother and their problems in life. Medicine is good for the sick body, but the sick mind and heart reach out to you for comfort and advice and help in the day when that counts. The general practitioner lives close to his patients. If he is a good one he will have the patience to listen and somehow hear the things left unsaid, so that he may know the half-conscious, subconscious anxiety, fear, or emotion that make the physical body sick, and with kindness and understanding be able to rebuild not only the physical but the spiritual life of his patient.

It has been a long road from the days of travel afoot, on horseback, by cart, by buggy, to the auto, and perhaps soon the gyroplane. There have been muddy roads, rain, snow, sleet, days and nights without sleep, meals on the table that were never eaten, trips that were never taken, shows that were never seen, family gatherings without you; yes, it has been a life of sacrifice to the call of the sick. Still there has been a richness, a fullness, a sense of service well performed, and for the most part a feeling that it was appreciated. The life of the general practitioner reaches out into the lives of his patients, into their days of trial, trouble, and suffering, and he brings to many a weary soul something that is more than elixir or pills. If the general practitioner is the man he should be, he carries to the bedside cheer, courage, and new hope. The trust he engenders in his patient often lifts the load off a tired heart or a troubled mind, and gives peace and rest that accomplishes more than medicine to heal and restore the broken body.

Life has brought to the general practitioner an ideal of service that goes beyond the requirements of business. To him it has been given to rejoice with his patients when a new life gives its first cry. His, it has been to close the eyes that will see no more. His, it has been to comfort the distressed, the troubled, the sorrowing. His, to bring order out of confusion in the day of grief. His, to weigh and determine what shall be done to restore health. His, to bring courage to face the inevitable. And his, to feel a sense of power within himself that is more than human, when after long hours by the bedside he sees his patient drop into peaceful sleep and knows that victory has been won.

When I began the study of medicine most of those about me felt a call, an inward urge to be a physician. Even as a man felt the call to the ministry, many of us felt such a call to service in the medical profession, and that feeling has come down through the years with the general practitioner. It has sustained him amidst the rigors of his profession, and although weary, tired, and exhausted, it has driven him to make one more call through the dark of the night, in the face of any weather, without regard for race, creed, or poverty; taking his pay as he found it, in meat, eggs, produce, labor, or money; and when there were not even these, he still went anyhow.

We have heard a lot about the patient-physician relationship and know that the loss of this relationship will result from political control of the practice of medicine. However, my experience of almost a half century makes me unafraid of the success of attempts at regimentation of our profession. The patient is a sick man, mentally or physically, or both, and he wants someone in whom he has faith and confidence. These two come from the contact the patient has with his physician over the years, years in which he has found his physician to be the one person, above all others, to whom he can go for help, and get that help instantly, honestly, sympathetically, and competently. And it is the general practitioner who has been in his life and home for years to whom he goes for care. One of the chief criticisms of the profession today is due to the increasing number of practitioners who have not felt that call to service which subordinates self to that service, but rather looks at their profession as a method of financial gain.

I am glad that I grew up in that day when men felt the urge of sacrifice, the urge to service, the urge which makes the welfare of their patient paramount to personal convenience. It has paid richly in the friendship, love, and respect which, now as one nears the end of his career, are more precious, more gratifying, and more comforting than all the stocks and bonds in safety boxes. The sense of a life spent in the care of others brings a reward that makes one glad he has been a general practitioner.

In spite of hardships and worry, it has been a pleasant and interesting half century. I have seen the petty jealousies and quarreling of the past generation give way to friendly relations and pleasant living with the fellow practitioner. Somehow we have retained the love and respect of our patients. As one grows older in the profession, this affection has ripened into an abundance of friendships that warms the heart and makes one feel that life has not been altogether in vain.

At the end we are again at the beginning, again the family physician, a part of the families we have cared for through the years. The courage and hope we have given them in their days of trial now come back to us, to make pleasant the days of our slipping toward the shadows.

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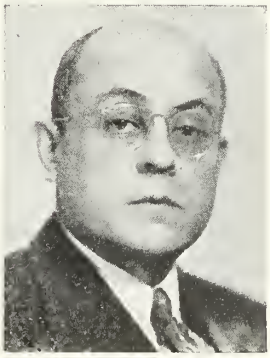
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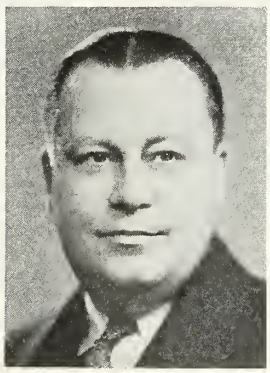
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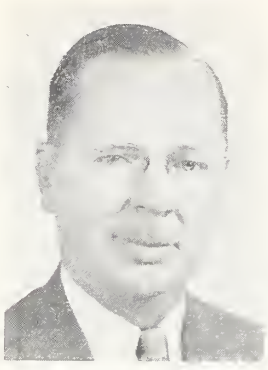
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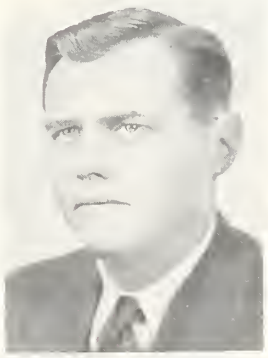
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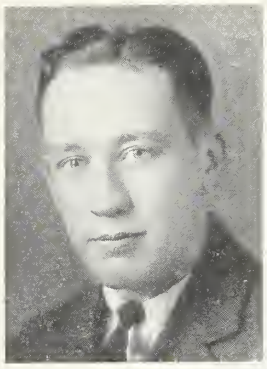
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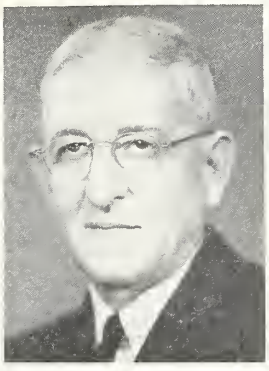
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O. E. WILSON
Secretary
Section on General Practice
Elkhart



H. C. WURSTER
Secretary
Section on Ophthalmology
and Otolaryngology
Mishawaka



MAYNARD A. AUSTIN
Editorial Board
Anderson



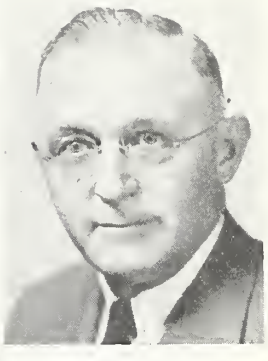
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President of the Woman's
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Fort Wayne

The Indianapolis Session

INDIANAPOLIS, HERE WE COME.

Let that be the slogan for every doctor and his wife in Indiana. Indianapolis is happy to welcome you to the ninety-seventh annual session of the Indiana State Medical Association, to be held at the Murat Temple, October 29, 30, and 31, 1946. Pack up your bags, guns, and golf clubs, and come to Indianapolis prepared to enjoy the big party as well as the practical scientific sessions. The members of the Indianapolis Medical Society are determined to make this the biggest and best meeting ever held, and they will be on hand to give you a royal welcome to the Hoosier capital city.

Indianapolis is one of the few made-to-order cities of the United States, being situated in almost the exact geographical center of the state and within seventy-five miles of the center of population of the United States; it is known as the "Crossroads of America."

Indianapolis has come a long way from that spring of 1820, when Jacob Whetzel and his son came from Andersontown and located at the confluence of Fall Creek and White River, after gaining permission from Chief Anderson of the Delaware Indians. The white man's treaty with Chief Anderson gave the venerable Delaware control over the entire area for one full year, and Whetzel was meticulous in his determination to observe that treaty. Perhaps the first family to settle here was that of George Pogue, who brought his wife and five children from Connersville and built a solid, double cabin for them; a little later John McCormick came and is supposed to have been the first permanent settler. The site of his cabin, near the Washington Street bridge over White River, is now marked by a bronze tablet.

The name "Indianapolis" suggested by Jeremiah Sullivan, Judge of the Supreme Court, was chosen because of the logical reasons for so naming the capital city. The name is indicative of the exact location—City of Indiana, or, as some have preferred, Indian City.

Indianapolis is a thriving, friendly, busy city, with every facility for the comfort and pleasure of the city's guests. It is teeming with industry, schools, and hospitals, and typical of the wide range of interesting places in Indianapolis are those illustrated here—scenes and structures you will long remember.

Of especial interest to visiting doctors are our pharmaceutical houses located in Indianapolis.



Aerial View showing Indiana State Soldiers' and Sailors' Monument, center of downtown Indianapolis.

PLACE OF MEETING

Murat Temple: Located at Massachusetts Avenue and New Jersey Street, the Murat Temple will be the headquarters for all scientific and general meetings of the convention, and offers ample facilities for these sessions as well as the scientific and commercial exhibits. Herein is housed the Murat Theater, Indianapolis' home of the Nobles of the Mystic Shrine.

HOSPITALS

Indianapolis offers some of the finest hospital facilities in the union. These hospitals include the Indiana University Medical Center, consisting of The James Whitcomb Riley Memorial Hospital, the Robert W. Long Hospital, and the William H. Coleman Hospital; the Indianapolis City Hospital; the Methodist Hospital; St. Vincent's Hospital; St. Francis Hospital; the Central State Hospital; the United States Veterans' Hospital; Sunnyside Hospital; and a number of privately-owned hospitals, including the Sterne Memorial Hospital and the Emhardt Memorial Hospital. Several of these hospitals have arranged medical and surgical clinics, with special exhibits and demonstrations, for October 29 and 30, so that Hoosier physicians may avail themselves of the opportunity to visit these institutions and benefit from their medical lore.

POINTS OF INTEREST

World War Memorial: One of the nation's most beautiful memorials to those who served their country is Indiana's World War Memorial Plaza, in Indianapolis. In this awe-inspiring panorama are the national headquarters of The American Legion; a formal mall leading to the cenotaph; a slender obelisk surrounded by color-lighted fountains; and the main shrine itself, a magnificent edifice of classic proportion.

Soldiers' and Sailors' Monument: Located in the center of downtown Indianapolis, dedicated to "Indiana's Silent Victors," is the impressive column

towering 284½ feet in height, considered the finest piece of monumental architecture in the world, and from its observation platform visitors may get a birdseye view of the city.

The John Herron Art Institute offers a permanent exhibit of beautiful paintings by European and American artists, drawings, etchings, sculpture, and medallic work.

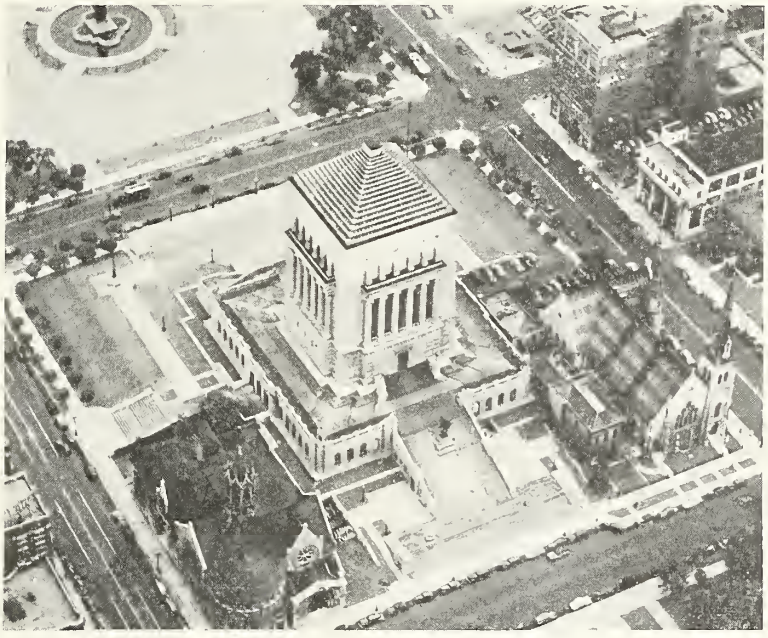
Scottish Rite Cathedral: A famed masterpiece of Old World architecture, its tower housing one of the finest carillons of the world.

Riley Home: The James Whitcomb Riley Home, on Lockerbie Street, a shrine to the immortal Hoosier Poet.

Benjamin Harrison Home: The historic home of Benjamin Harrison, twenty-third President of the United States. The home is open to visitors and adjoins the grounds of the Arthur Jordan Conservatory of Music. Its furnishings are of the Gay Nineties period.



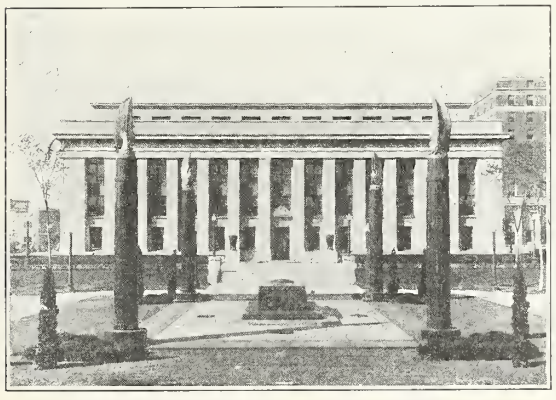
John Herron Art Institute



The Indiana World War Memorial

Other points of interest include the Indianapolis Motor Speedway, the scene of the annual Memorial Day five-hundred-mile classic; Perry Stadium, the "Indians" Victory Field; the Naval Armory, training center for the Indiana Naval Reserve, one of the nation's finest inland naval training schools, and numerous beautiful parks.

Indianapolis is a center of education, representing every branch of education. It is the seat of the Indiana University School of Medicine and the Indiana University School of Dentistry; Butler University; the Indiana Central College; and it abounds with cultural facilities, its public library system including a central library and twenty-one branch libraries, and the State Library. It is known as the home of many famous writers, including James Whitcomb Riley, poet; Booth Tarkington, novelist and dramatist and twice winner of the Pulitzer Prize in fiction; Meredith Nicholson, poet, novelist and diplomat; Albert J. Beveridge, statesman and author of "The Life of John Marshall"; tournament, Tuesday afternoon, which will be played at the Indianapolis Country Club.



National Headquarters of the American Legion

GOLF

The first recreational feature will be the golf tournament, Tuesday afternoon, which will be played at the Indianapolis Country Club.

TRAP AND SKEET SHOOT

The annual trap and skeet shoot will be held at the Indiana Gun Club, Tuesday afternoon.

TRANSPORTATION

Indianapolis is a principal gateway for all manner of surface transportation; is served by sixteen railroad lines; is the center of one of the world's finest highway systems; and has gained importance as a world airport—Weir Cook Municipal Airport being one of the largest and best equipped in the world.



Taggart Memorial—Riverside Park



Indianapolis Country Club

The war restrictions which hampered our annual sessions in recent years are now a matter of history, and we have again returned to peacetime pursuits, but the unbelievable advances made in scientific medicine make it imperative that we keep alert to the swift changes and the progress brought about as a result of the impetus of war. Medical meetings serve to promote postgraduate stimulation, the exchange of ideas, and we gain knowledge from association with our fellow workers, and glean new information from those who served in the armed forces, whose new experiences and enthusiasm often spur us on to greater fields of endeavor.

Recognizing the value of Scientific Exhibits, a number of excellent ones have been planned for this meeting, and it will be well worth your time to visit these booths. Exhibits will be featured by the American Medical Association; the Indiana Tuberculosis Association; the Indiana Pharmaceutical Association; the Indiana Cancer Society and the Indiana State Association of Pathologists; the Tumor Clinic of the Indianapolis City Hospital; the Lilly Laboratory for Clinical Research, Indianapolis City Hospital; the Indiana University Medical Center; the Indiana State Board of Health; the Central State Hospital, the American Social Hygiene Association, and the National Society for the Prevention of Blindness; the Indianapolis City Hospital; and the Indiana Hospital Council.

The scientific program is one of the best ever assembled, and the following out-of-state speakers will take part in these sessions: H. Dabney Kerr, M.D., of the State University of Iowa College of Medicine, Iowa City, Iowa; Wallace E. Herrell, M.D., Rochester, Minnesota; Karl A. Meyer, M.D., of the Northwestern University Medical School; Stanley T. Garber, M.D., Cincinnati, Ohio; Howard D. Fabing, M.D., of the University of Cincinnati College of Medicine, Cincinnati, Ohio; Albert D. Ruedemann, M.D., Cleveland, Ohio; and Ralph T. Knight, M.D., of the University of Minnesota Medical School, Minneapolis, Minnesota. Olin West, M.D., president-elect of the American Medical Association, Nashville, Tennessee, and Jack Major, of Paducah, Kentucky, will be the speakers at the Annual Dinner.

Plan to attend the ninety-seventh annual session of the Indiana State Medical Association. It offers you an opportunity to renew professional friendships and to acquire new knowledge through its various activities, including the scientific sessions, instructional courses, and scientific and technical exhibits.



Arthur Jordan Memorial Hall, Butler University.

Official Program

NINETY-SEVENTH ANNUAL SESSION

INDIANA STATE MEDICAL ASSOCIATION

MURAT TEMPLE

508 North New Jersey Street

INDIANAPOLIS, INDIANA

October 29, 30, 31, 1946

(Schedule will be carried out on Central Standard Time.)

Monday, October 28, 1946

Annual Indiana Health Officers' Conference, Hurty Hall, State Board of Health Building, Indiana University Medical Center.

6:30 p.m. Executive Committee dinner and meeting, Columbia Club.

Tuesday, October 29, 1946

Morning

8:00 a.m. Registration starts, lounge room, Murat Temple.

8:00 a.m. Opening of Scientific and Commercial Exhibits, Lounge Room, Murat Temple.

11:00 a.m. Instructional Courses, Murat Temple.

11:00 a.m. Editorial Board Meeting, Committee Room, northwest corner Lounge Room, Murat Temple.

12:00 m. Annual Golf Tournament. Low gross and handicap medal play. Indianapolis Country Club.

12:00 m. Annual Trap and Skeet Shoot, Indiana Gun Club.

Afternoon

12:30 p.m. Council Meeting, Kneipe Room, Murat Temple.

1 to 5 p.m. Instructional Courses, Murat Temple.

4:00 p.m. Meeting of House of Delegates, Murat Theater.

Evening

6:30 p.m. Annual Dinner meeting for women physicians, Athenaeum.

7:00 p.m. Buffet supper, smoker and stag party, Recreation Room, Murat Temple. Award of Golf, Trap and Skeet Shoot prizes.

9:00 p.m. Theater Party, Murat Theater.

Wednesday, October 30, 1946

Morning

7:30 a.m. Breakfast meeting of Committee on Secretaries' Conference, Hotel Lincoln.

7:30 a.m. Breakfast meeting of Committee on Industrial Health, Hotel Lincoln.

8:00 a.m. Registration continues, Lounge Room, Murat Temple.

8:00 a.m. Scientific and Commercial Exhibits, Lounge Room, Murat Temple.

GENERAL MEETING

MURAT THEATER

October 30, 1946

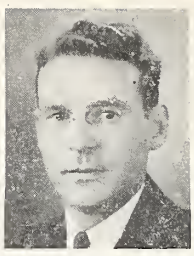
9:00 a.m. Call to order by J. E. Ferrell, M.D., Fortville, President of the Indiana State Medical Association.

9:05 a.m. Greetings and introduction of E. Vernon Hahn, M.D., Indianapolis, President of the Indianapolis Medical Society, by Gordon W. Batman, M.D., chairman of the Committee on Convention Arrangements.
Official Welcome by E. Vernon Hahn, M.D.

9:10 a.m. President's Address, J. E. FERRELL, M.D., Fortville.



H. DABNEY KERR, M.D.
Professor of Radiology, State University of Iowa College of Medicine, Iowa City, Iowa



WALLACE E. HERRELL, M.D.
Rochester, Minnesota

SCIENTIFIC PROGRAM

Wednesday, October 30, 1946

Morning

9:30 a.m. H. DABNEY KERR, M.D., Professor of Radiology, State University of Iowa College of Medicine, Iowa City, Iowa.

Subject: *Irradiation in Vaginal Bleeding.*

10:00 a.m. WALLACE E. HERRELL, M.D., Rochester, Minnesota.

Subject: *The Clinical Use of Streptomycin.*

10:30 a.m. KARL A. MEYER, M.D., Professor of Surgery, Northwestern University Medical School, Chicago, Illinois.

Subject: *Carcinoma of the Bowel.*

11:00 a.m. STANLEY T. GARBER, M.D., Cincinnati, Ohio.

Subject: *Toxemia of Pregnancy.*

11:30 a.m. HOWARD D. FABING, M.D., Professor of Neurology, University of Cincinnati College of Medicine, Cincinnati, Ohio.

Subject: *Evaluation of Neuropsychiatry.*

Noon

12:00 m. Luncheon meeting, Indiana Roentgen Society, Indianapolis Athletic Club.

Speaker: H. DABNEY KERR, M.D., Iowa City, Iowa.

Subject: *Further Observations on Irradiation of Pituitary Tumors.*

Noon

12:00 m. Reunion of 1910 Class of Indiana University School of Medicine. Luncheon at the Athenaeum.

12:00 m. Phi Beta Pi Luncheon, Athenaeum.

12:15 p.m. Luncheon meeting of members of the State and County Anti-Tuberculosis Committees, Banquet Hall, Basement, Murat Temple. Indiana Chapter of American College of Chest Physicians participating.

Speaker: HAROLD C. OCHSNER, M.D., Indianapolis.

Subject: *"Report of Routine Photo-Fluorographic Chest Examinations of General Hospital Admissions."*

Discussion:

Raymond C. Beeler, M.D., Indianapolis.
M. H. Draper, M.D., Fort Wayne.
E. W. Custer, M.D., South Bend.

General discussion.

X-ray conference sponsored by Indiana Chapter, American College of Chest Physicians.

12:15 p.m. Indiana Medical College Class of 1907 luncheon, Indianapolis Athletic Club.

12:15 p.m. Loyola University Alumni luncheon, Athenaeum.

12:15 p.m. Servicemen's luncheon, Kneipe Room, Murat Temple.



KARL A. MEYER, M.D.
Professor of Surgery, Northwestern University Medical School, Chicago, Illinois



STANLEY T. GARBER, M.D.
Cincinnati, Ohio



HOWARD D. FABING, M.D.
Professor of Neurology, University of Cincinnati College of Medicine, Cincinnati, Ohio

SECTION MEETINGS

Wednesday, October 30, 1946

MEDICAL SECTION

Chairman, Marion R. Shafer, M.D., Indianapolis
Vice-chairman, William M. Dugan, M.D., Indianapolis
Secretary, Maurice E. Glock, M.D., Fort Wayne

(Murat Theater)

October 30, 1946

Afternoon

2:00 p.m. BRANDT F. STEELE, M.D., Indianapolis.
Subject: *Recurrent Malaria in Veterans.*
2:20 p.m. Discussion.
2:25 p.m. A. N. FERGUSON, M.D., Fort Wayne.
Subject: *Heart Failure.*
2:45 p.m. Discussion.
2:50 p.m. STANTON L. BRYAN, M.D., Evansville.
Subject: *Diabetic Coma.*
3:10 p.m. Discussion.
3:15 p.m. HOWARD D. FABING, M.D., Cincinnati, Ohio.
Subject: *Practical Considerations in the Management of the Epileptic Patient.*
4:00 p.m. Election of Section Officers.

SURGICAL SECTION

Chairman, J. Robert Doty, M.D., Gary
Vice-chairman, William N. Wishard, Jr., M.D., Indianapolis
Secretary, Harold D. Caylor, M.D., Bluffton

(Murat Candidates Room)

October 30, 1946

2:30 p.m. KARL A. MEYER, M.D., Chicago, Illinois.
Subject: *Recent Surgical Advances in the Treatment of Ulcers of the Duodenum.*
3:00 p.m. C. O. ALMQUIST, M.D., Gary.
Subject: *Lesions of the Stomach.*
Discussion: H. W. Detrick, M.D., Hammond.
3:30 p.m. RALPH MORTON BOLMAN, JR. M.D., Fort Wayne.
Subject: *Emergency Thoracic Surgery.*
Discussion: Hawthorne Wallace, M.D., Crawfordsville.
4:00 p.m. CLEON A. NAFE, M.D., Indianapolis.
Subject: *The Significance of Breast Changes.*
Discussion: Robert M. Sherman, M.D., Bluffton.
4:30 p.m. Election of Section Officers.

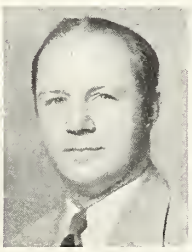
SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman, J. V. Cassady, M.D., South Bend
Vice-chairman, Edgar C. Davis, M.D., Muncie
Secretary, H. C. Wurster, M.D., Mishawaka

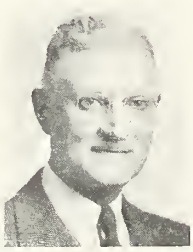
(Foyer, Murat Egyptian Room)

October 30, 1946

2:00 p.m. MARY ALICE NORRIS, M.D., Indianapolis.
Subject: *An Outline for the Study of Strabismus Cases.*
Discussion: Bernard J. Larkin, M.D., Indianapolis.
2:30 p.m. JOSEPH LARMORE, M.D., Anderson.
Subject: *Tertiary Syphilis of the Larynx.*
Discussion: Marlow W. Manion, M.D., Indianapolis.
3:00 p.m. MALCOLM MILLER, M.D., Goshen.
Subject: *The Use of Penicillin Locally in the Eye.*
Discussion: Edwin W. Dyar, M.D., Indianapolis.



ALBERT D. RUEDEMANN, M.D.
Cleveland, Ohio



RALPH T. KNIGHT, M.D.
Associate Professor of Surgery and Anesthesiology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota



OLIN WEST, M.D.
President-elect,
American Medical Association,
Nashville, Tennessee

3:30 p.m. ERNEST L. DIETL, M.D., South Bend.

Subject: *The Treatment of Chronic Otitis Media.*

Discussion: Robert M. Dearmin, M.D., Indianapolis.

4:00 p.m. ALBERT D. RUEDEMANN, M.D., Cleveland, Ohio.

Subject: *External Diseases of the Eye: Diagnosis and Treatment.*

4:30 p.m. Election of Section Officers.

SECTION ON ANESTHESIA

Chairman, John M. Whitehead, M.D., Indianapolis
Vice-chairman, Frank W. Ratcliff, M.D., Lafayette
Secretary, Roy A. Geider, M.D., Indianapolis

(Officers Room)

October 30, 1946

2:00 p.m. RALPH T. KNIGHT, M.D., Associate Professor of Surgery and Anesthesiology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis, Minnesota.

Subject: *Curare in Anesthesia.*

2:30 p.m. FLOYD T. ROMBERGER, M.D., Lafayette.

Subject: *Ten Thousand Spinal Anesthesias; Five Thousand with Ephedrine Intrathecally—Random Comment.*

3:00 p.m. WILLIAM B. ADAMS, M.D., Muncie.

Subject: *Anesthesia for Cardiac Patients.*

3:30 p.m. General discussion.

4:00 p.m. Election of Section Officers.

SECTION ON GENERAL PRACTICE

Chairman, J. T. Oliphant, M.D., Farmersburg
Vice-chairman, Claude S. Black, M.D., Warren
Secretary, O. E. Wilson, M.D., Elkhart

(Ballroom)

October 30, 1946

2:00 p.m. STANLEY T. GARBER, M.D., Cincinnati, Ohio.

Subject: *Obstetrics.*

2:30 p.m. GEORGE S. BOND, M.D., Indianapolis.

Subject: *Management of Chronic Myocardial Disease with Failing Heart.*

3:00 p.m. JAMES O. RITCHEY, M.D., Indianapolis.

Subject: *The Spastic Colon.*

3:30 p.m. Awarding of Certificates of Membership to members of the Founders' Group of the Indiana Board of General Practice of Medicine.

4:00 p.m. Election of Section Officers.

Annual Dinner

October 30, 1946

Evening

7:30 p.m. Annual Dinner, Banquet Hall, Murat Temple.

Presiding officer, J. E. Ferrell, M.D., President of the Indiana State Medical Association.

Presentation of Certificate of Merit to N. K. Forster, M.D., President in 1945, by J. E. Ferrell, M.D.

Speaker: OLIN WEST, M.D., Nashville, Tennessee. President-elect of the American Medical Association.

Subject: *The American Medical Association.*

Entertainment: JACK MAJOR, Paducah. "The Colonel from Kentucky."

Thursday, October 31, 1946

7:15 a.m. House of Delegates' breakfast meeting, Chateau Room, first floor, Claypool Hotel. Annual election of officers and selection of convention city for 1947.

Meeting of Council immediately following adjournment of House of Delegates.

SPECIAL EXHIBITS AND DEMONSTRATIONS

Schedules of Medical and Surgical Clinics and of special exhibits and demonstrations available for visitation on Tuesday, October 29, and Wednesday, October 30, will be posted at the Registration Desk at the Murat Temple. These are being prepared with utmost care to insure proper instruction of those interested in the subjects. Transportation directions and guides will be available for those desiring to attend these away-from-the-Murat-Temple affairs. Look on the bulletin board for the schedules, and get out to see the things you find interesting. The Indianapolis hospitals will be open for your inspection and instruction. Make these two days show you something new which you can take home with you and use.

Women's Entertainment

Tuesday, October 29, 1946

8:30 a.m. Registration, Lounge Room, Murat Temple.

1:00 p.m. Meeting of State Board members, Committee Room, northwest corner lounge room, Murat Temple.

6:00 p.m. Dinner (Hallowe'en party) for all women attending convention, Athenaeum.

9:00 p.m. Entertainment for physicians and wives and guests, Murat Theater.

Wednesday, October 30, 1946

10:00 a.m. Business meeting, Woman's Auxiliary to the Indiana State Medical Association, Indiana World War Memorial, honoring members at large. Mrs. Samuel J. Petronella, East Chicago, President of the Woman's Auxiliary to the Indiana State Medical Association, will preside.

12:00 m. Luncheon, Columbia Club.

Speaker: N. K. FORSTER, M.D., immediate past president of the Indiana State Medical Association.

Bridge for those who wish to play.

7:30 p.m. Annual Dinner in conjunction with Indiana State Medical Association, Banquet Hall, Murat Temple.

SCIENTIFIC EXHIBIT

C. G. Culbertson, M.D., Indianapolis, Chairman.
J. L. Arbogast, M.D., Indianapolis.
Ernest Rupel, M.D., Indianapolis.
James N. Collins, M.D., Indianapolis.
K. G. Kohlstaedt, M.D., Indianapolis.

MURAT TEMPLE

1. "Food Poisoning and Food-borne Infections."
"Diseases Transmitted from Animals to Man."
American Medical Association.

2. "Tuberculosis Control."
Indiana Tuberculosis Association.

3. "Modern Pharmacy."
Indiana Pharmaceutical Association.

4. "Teamwork in Cancer Diagnosis."
Indiana Cancer Society and
Indiana State Association of Pathologists.

5. "Hidden Cancer of the Endocervix, Early and Late."
Tumor Clinic, Indianapolis City Hospital
William B. Dublin, M.D., and
J. William Hofmann, M.D.

6. "Methods for Clinical Evaluation of Hypertension."
Lilly Laboratory for Clinical Research,
Indianapolis City Hospital
K. G. Kohlstaedt, M.D.
James D. Peirce, M.D.
O. M. Helmer, Ph.D.
Robert E. Shipley, M.D.

7. "Pinworm Infections in Indiana."
Indiana University Medical Center
William Hugh Headlee, Ph.D.

8. "Indiana State Board of Health."
Indiana State Board of Health.

9. "Syphilitic Optic Atrophy—Pathogenesis and Treatment."
Walter L. Bruetsch, M.D., and
Max A. Bahr, M.D.,
Central State Hospital, Indianapolis;
Walter Clarke, M.D.,
American Social Hygiene Association, New York;
Conrad Berens, M.D.,
National Society for the Prevention of Blindness, New York.

10. "Cirrhosis of the Liver."
Gastro-intestinal Department,
Indianapolis City Hospital
Rollin H. Moser, M.D.
Bernard D. Rosenak, M.D.

11. "Tuberculosis in Children."
Indiana University Medical Center
Frank Forry, M.D.

12. "Plastic and Reconstructive Surgery."
Indiana University Medical Center
Harold M. Trusler, M.D.
Thomas B. Bauer, M.D.

13. Indiana Hospital Council.

ANNUAL CONFERENCE
INDIANA STATE BOARD OF HEALTH WITH LOCAL HEALTH OFFICERS
and
INDIANA HEALTH OFFICERS ASSOCIATION

HURTY HALL, INDIANA STATE BOARD OF HEALTH

INDIANAPOLIS

October 28 and 29, 1946

Monday, October 28

Indiana State Board of Health with Local Health Officers:

Presiding—L. E. Burney, M.D., State Health Commissioner.

1:30- 2:30 p.m. Proposed Public Health Legislation.

2:30- 3:30 p.m. Discussion of Legislation.

3:30- 4:30 p.m. General Discussion of Problems by Health Officers.

6:30 p.m. Annual Banquet, Indiana Health Officers Association, Travertine Room, Lincoln Hotel.

Presiding—F. R. Nicholas Carter, M.D., President, Indiana Health Officers Association, South Bend.

Trends in Public Health, HENRY VAUGHAN, Dr. P.H., Dean of the School of Public Health, University of Michigan.

Tuesday, October 29

Indiana State Board of Health with Local Health Officers (open to all persons interested in public health):

Presiding—L. E. Burney, M.D., State Health Commissioner.

9:00-10:00 a.m. *Intensive Treatment of Syphilis*, UDO J. WILE, M.D., Professor of Dermatology and Syphilology, University of Michigan.

Discussion—Minor Miller, M.D., Evansville.

10:00-11:00 a.m. *Experiences in Local Health Administration*, HENRY VAUGHAN, Dr. P.H., Dean of the School of Public Health, University of Michigan.

Discussion—Paul J. Bronson, M.D., City Health Officer, Terre Haute.
Richard Boyd, M.D., Director, Division of Local Health Administration, Illinois State Board of Health.

11:00-12:00 a.m. *Teamwork in School Health*, W. W. PATTY, Ph.D., Dean of the School of Health, Physical Education and Recreation, Indiana University.

Discussion—Robert Yoho, Director of the Division of Health and Physical Education, Indiana State Board of Health.

Indiana Health Officers Association:

Presiding—F. R. Nicholas Carter, M.D., President, South Bend.

2:00- 4:30 p.m. Business Meeting.

FIRST REQUIREMENT OF GOOD PUBLIC RELATIONS

It is impossible to "sell" the medical profession to the American people unless the medical profession constantly renders the highest quality of medical service.

The results of the finest public relations program can be "entirely undone by one scandalous action of a member of the medical society."

We must constantly keep in mind that our prime responsibility to the American people is the rendering of the highest quality of medical service.

A profession exists for the service it can render mankind. We have always fought for a high standard of education—one of the greatest assets of American Medicine—for high standards of hospitals and certifying boards. These are to protect the public—not the doctor—and now certain forces are attempting to lower those standards.

Thirty-three per cent of the pneumonia cases died in World War I, as compared with one-half of one per cent in World War II. There was not one devastating epidemic among the services in this last war. In 1945 a total of thirty-eight cities in the United States had no deaths from diphtheria.—*The Pennsylvania Medical Journal.*

COMMITTEES IN CHARGE OF THE LOCAL ARRANGEMENTS

ANNUAL SESSION

INDIANA STATE MEDICAL ASSOCIATION

General Chairman.....Gordon W. Batman.

Assistant General Chairman.....Brandt Steele.

Instructional Course Committee.....Russell Sage, Chairman; Frank B. Ramsey, Gordon W. Batman.

Smoker and Luncheon Menus.....C. E. Cox, W. Cort Davidson.

Banquet Committee.....Ben B. Moore, Chairman; Foster Hudson, Gordon W. Batman, James N. Collins, C. E. Cox, Otto Bakemeier, E. B. Lamb, David L. Smith, Howard Norris, Martha Souter.

Theater Show Committee.....C. F. Thompson, Chairman; William Dugan, Brandt Steele, Byron K. Rust, Robert Fry, Chet Lamber, Arthur B. Richter, William Loehr.

Sports Program Golf Committee: Russell Hippensteel, Chairman; Harry Kerr, Edwin Dyer, T. V. Petranoff, Edwin Eaton, William D. Gambill, Howard Beaver.

Shoots Committee.....H. M. Banks, Chairman; L. A. Ensminger, Harold Adkins, H. B. Cox.

Reception Committee.....James N. Collins, Chairman; Bert E. Ellis, Paul Cullen, Karl M. Koons, Walter D. Close, Louis D. Belden, Wendell E. Brown, Edmund B. Haggard, Neil Garber, James S. McBride, Ralph U. Leser, O. B. Norman, Ray Tharpe, Glen Ryan, Russell Spivey, Charles Williams, Jeane Waldo.

Women Physicians Banquet.....Martha Souter, Chairman; Mary Alice Norris, Assistant Chairman; Frances Brown, Olga Bonke Booher.

Woman's Auxiliary Program.....Mrs. E. B. Lamb, President, Indianapolis Medical Society; Mrs. John W. Carmack, General Chairman; Mrs. Gerald Gustafson, Mrs. Henry Leonard, Mrs. J. E. Holman, Jr., Mrs. Basil Fausset, Mrs. Karl M. Koons.

Luncheon Arrangements.....John W. Hendricks, Chairman.

Budget Director.....Joseph W. Ricketts, Director.

REFERENCE COMMITTEES — 1946

1. SECTIONS AND SECTION WORK:
Chairman, J. E. Dudding, Hope (Bartholomew).
C. E. Weddle, Lebanon (Boone).
J. R. Nash, Albion (Noble).
Julia Thom, Spencer (Owen).
J. Guy Hoover, Boonville (Warrick).

2. RULES AND ORDER OF BUSINESS:
Chairman, V. L. Turley, Fowler (Benton).
J. T. Carney, Jeffersonville (Clark).
E. B. Lett, Loogootee (Daviess-Martin).
J. H. Barrow, Dale (Spencer).
Earl B. Jewell, Logansport (Cass).

3. MEDICAL EDUCATION AND HOSPITALS:
Chairman, Bruce W. Stocking, Muncie (Delaware-Blackford).
Herman Smelser, Connersville (Fayette-Franklin).
W. G. Pippenger, Brook (Jasper-Newton)
P. Q. Row, Hammond (Lake).
Roy A. Geider, Indianapolis (Marion).

4. PUBLIC POLICY AND LEGISLATION:
Chairman, Harry L. Foreman, Indianapolis (Marion).
A. T. Jones, Pendleton (Madison).
C. E. Boyd, West Baden Springs (Orange).
W. D. Inlow, Shelbyville (Shelby).
F. R. N. Carter, South Bend (St. Joseph).

5. PUBLICITY:
Chairman, Russell Lavengood, Marion (Grant).
O. T. Scamahorn, Pittsboro (Hendricks).
A. C. Yoder, Goshen (Elkhart).
J. L. Allen, Greenfield (Hancock).
M. B. Catlett, Fort Wayne (Allen).

6. HYGIENE AND PUBLIC HEALTH:
Chairman, William H. Garner, New Albany (Floyd).
L. W. Painter, Winchester (Randolph).
Harold D. Caylor, Bluffton (Wells).
Harry P. Ross, Richmond (Wayne-Union).
S. M. Cotton, Goldsmith (Tipton).

7. AMENDMENTS TO CONSTITUTION AND BY-LAWS:
Chairman, C. V. Rozelle, Anderson (Madison).
Raymond C. Beeler, Indianapolis (Marion).
Oran Province, Franklin (Johnson).
Gordon A. Thomas, Lafayette (Tippecanoe).
R. Lee Smith, Osgood (Ripley).

8. REPORTS OF OFFICERS:
Chairman, O. G. Brubaker, North Manchester (Wabash).
E. R. Clarke, Kokomo (Howard).
G. L. Verplank, Gary (Lake).
C. F. Briggs, Sullivan (Sullivan).
R. B. Johnson, Rushville (Rush).

9. COMMITTEE ON CREDENTIALS:
Chairman, C. M. Clark, Oakland City (Gibson).
Floyd S. Napper, Scottsburg (Scott).
Gilbert D. Rhea, Greencastle (Putnam).
J. Frank Maurer, Brazil (Clay).
John S. Hash, Noblesville (Hamilton).

10. COMMITTEE ON MISCELLANEOUS BUSINESS:
Chairman, M. C. Topping, Terre Haute (Vigo).
A. E. Stinson, Rochester (Fulton).
King L. Hull, Bloomfield (Greene).
A. A. Thompson, Tyner (Marshall).
Frederick K. Allen, Salem (Washington).

ORDER YOUR TICKETS FOR THE 1946 INSTRUCTIONAL COURSE NOW!

The schedule of classes for the 1946 Instructional Courses, offered as a feature of the Annual Session of the Indiana State Medical Association, at Murat Temple, Indianapolis, is now complete. All classes are to be held on Tuesday, October 29, 1946.

Admission to each class will be by ticket, and not more than thirty will be admitted to any class. The cost is $1.00 per class with a maximum charge of $3.00 for three or more classes. Plan your course to include five classes. (And please note second choices.) Enclose your check made payable to "Instructional Course Committee." Do it now!

INSTRUCTIONAL COURSE SCHEDULE

Hours	*Officers' Room*	*Candidates' Room 1*	*Candidates' Room 2*	*Directors' Room*	*Foyer*
11:00 A.M.	Diagnosis and Care of Rheumatic Fever — Course 1	Office Treatment of Genito-urinary Conditions — Course 6	Orthopedics in General Practice — Course 11	Headache — Course 16	Diagnosis and Treatment of Common Skin Diseases — Course 21
1:00 P.M.	Infant Feeding — Course 2	The Status and Use of Penicillin and Sulfa Drugs — Course 7	Backache — Course 12	Office and Bedside Heart Examination — Course 17	Diagnosis and Treatment of Eye Conditions in General Practice — Course 22
2:00 P.M.	Immunization — Course 3	Office Laboratory Procedures — Course 8	Diagnosis and Treatment of Common Skin Diseases — Course 13	Management of the Elderly — Course 18	Management of Diabetes Mellitus — Course 23
3:00 P.M.	Prenatal Care — Course 4	Treatment of Burns — Course 9	Office Treatment of Anorectal Conditions — Course 14	Psychological Management of Patients — Course 19	Office and Bedside Heart Examinations — Course 24
4:00 P.M.	Obstetrical Anesthesias — Course 5	What to Expect from X-rays and X-ray Therapy — Course 10	Office Surgery of Ear, Nose and Throat — Course 15	Treatment of the Menopause — Course 20	Management of Colitis and Constipation — Course 25

Cut on dotted line.

APPLICATION BLANK

Instructional Course Committee,
c/o Gordon W. Batman, M.D.,
723 Hume Mansur Building,
Indianapolis 4, Indiana.

Enclosed find check for $1.00; $2.00; $3.00. Please reserve tickets for the following Instructional Courses:

	11:00 A.M.	1:00 P.M.	2:00 P.M.	3:00 P.M.	4:00 P.M.
First choice...	No.:	No.:	No.:	No.:	No.:
Second choice.	No.:	No.:	No.:	No.:	No.:

(Insert course numbers plainly, please.)

Your tickets will be waiting for you at the Registration Desk, October 29, 1946.

Signed: .....M.D.

Address:.....

OPEN LETTER TO THE CONVENTION VISITORS OF THE INDIANA STATE MEDICAL ASSOCIATION

The Committee on Convention Arrangements wishes to emphasize that the center for all activities of the annual session of the Indiana State Medical Association will be at the Murat Temple. Come directly there as early as possible on Tuesday, October 29, 1946, register, and get into the swing of the session. This registration center also includes the starting point for activities planned for doctors' wives. Parking lots in the immediate vicinity of the Murat will be posted for out-of-town physicians. Put your "Doctors Car" sticker on your windshield.



MURAT TEMPLE

Headquarters for the ninety-seventh annual session of the Indiana State Medical Association, to be held in Indianapolis on October 29, 30, and 31, will be the Murat Temple. Registration, Scientific Exhibits, Commercial Exhibits, scientific meetings, the business sessions of the House of Delegates and Council, annual dinner meeting, and practically all activities of the state meeting are to be held in the Temple and the spacious and convenient Murat Theater of the Temple.

The Exhibitors Hall and the Scientific Exhibits will be open throughout all convention hours and will merit much of your attention. Try to visit each booth and see the newest offerings of our commercial friends.

The first scheduled sessions are those of the Instructional Courses, starting at 11:00 a.m. on Tuesday, October twenty-ninth, and continuing at 1:00, 2:00, 3:00, and 4:00 p.m. If you have not sent in your request for Instructional Courses, turn to page 516 of this issue of THE JOURNAL and fill out the application blank now. The advance reservations made to date have been greater than in previous years, and we expect a complete sell-out.

The Golf Tournament and Trap and Skeet Shoots scheduled for Tuesday afternoon can be reached easily from the Murat, and transportation arrangements will be provided for those desiring it. Travel directions to these events can be obtained at the registration desk. Both events will be completed in ample time to permit attendance at dinner functions.

Tuesday evening is a gala evening of entertainment. For the early part of the evening, three affairs are scheduled for identical hours: the Smoker for men members at the Murat; the Annual Party for women members at the Athenaeum; and a Dinner for physicians' wives, also at the Athenaeum. At 9:00 p.m., the three parties merge in the Murat Theater for a show—and a very good show, too, we are assured.

On Wednesday the convention gets down to business, with general and sectional meetings. The programs for these are listed elsewhere in THE JOURNAL. Wednesday evening the convention proper closes with the Annual Banquet. This is the crowning event of the session, and it will be possible to accommodate all who wish to attend. Plan to be at the Banquet!

Can you afford to miss any part of this session? Yes, the answer is "No."

COMMITTEE ON CONVENTION ARRANGEMENTS

Announcements

LOYOLA ALUMNI LUNCHEON

The Loyola University alumni will meet at a luncheon at 12:15 P.M. on Wednesday, October 30, at the Athenaeum.

EDITORIAL BOARD MEETING

A meeting of the Editorial Board of THE JOURNAL of the Indiana State Medical Association will be held in the Committee Room, northwest corner lounge room, Murat Temple, at 11:00 A.M., on Tuesday, October 29, 1946.

INSTRUCTIONAL COURSES

The Instructional Courses scheduled for this year's annual session of the Indiana State Medical Association will be held at the Murat Temple, on Tuesday, October 29, at 11:00 A.M.; 1:00; 2:00; 3:00; and 4:00 P.M.

DINNER FOR WOMEN PHYSICIANS

The annual dinner for women physicians will be held at the Athenaeum on Tuesday, October 29, at 6:30 P.M.

SERVICEMEN'S LUNCHEON

All servicemen are invited to attend a luncheon at 12:15 P.M., Wednesday, October 30, 1946, in the Kneipe Room of the Murat Temple. Reservations should be made at the registration desk. There will not be any set speaking program, but a general discussion of matters of interest to former medical officers.

1907 CLASS LUNCHEON

The Indiana Medical College Class of 1907 will have a luncheon meeting at the Indianapolis Athletic Club, at 12:15 P.M., on Wednesday, October thirtieth.

1910 CLASS REUNION

A reunion of the 1910 class of the Indiana University School of Medicine will be held at 12:00 noon, Wednesday, October 30, 1946, at the Athenaeum.

INDIANA ROENTGEN SOCIETY LUNCHEON

The Indiana Roentgen Society will hold a luncheon meeting at the Indianapolis Athletic Club at 12:00 M., on Wednesday, October thirtieth.

PHI BETA PI

Phi Beta Pi will hold an alumni luncheon Wednesday noon, October 30, at the Athenaeum.

LUNCHEON OF ANTI-TUBERCULOSIS COMMITTEES

A luncheon meeting of members of the State and County Anti-Tuberculosis Committees will be held at 12:15 P.M., in the Banquet Hall, Basement, of the Murat Temple, with the Indiana Chapter of American College of Chest Physicians participating.

NOTICE! TUESDAY NOON LUNCHEONS

Arrangements have been made to operate luncheon facilities for any and all members and guests attending sessions at the Murat Temple on Tuesday and Wednesday at noon. Any class, fraternity or other group desiring special luncheon arrangements may secure whatever accommodations are desired by addressing Dr. John W. Hendricks, 911 Hume-Mansur Building, Indianapolis 4, Indiana. Such a request should be made very soon.

ATTENTION ALL SHOOTERS!

This Is a Must.

All members who desire to enter the Trap and Skeet Shoots arranged for Tuesday, October 29, 1946, at the Indiana Gun Club, at 38th Street and Post Road, as a feature of the Annual Session of the Indiana State Medical Association, must fill out the questionnaire which appeared on page 460 in the September issue of THE JOURNAL and mail it at once to:

No sign-up—no Trap Shoot!

H. M. BANKS, M.D., *Chairman,*
1604 North Capitol Avenue,
Indianapolis 7, Indiana.

ATTENTION ALL GOLFERS!

This Is a Must.

All members playing in the State Medical Association Tournament at the Indianapolis Country Club, on Tuesday, October 29, 1946, must send in their reservations for the Golfer's Luncheon to the undersigned, not later than October 20, 1946.

RUSSELL HIPPENSTEEL, M.D., *Chairman,*
3740 Central Avenue,
Indianapolis 8, Indiana.

WOMEN CORDIALLY INVITED!

The Woman's Auxiliary to the Indianapolis (Marion County) Medical Society extends a cordial invitation to the members of The Woman's Auxiliary to the Indiana State Medical Association and to physicians' wives to attend the activities scheduled in connection with the annual session of the Indiana State Medical Association, October 29 and 30, 1946. We want you to come—please join us in Indianapolis.

MRS. JOHN CARMACK, *Chairman,*
General Convention Arrangements.

MRS. EMMETT B. LAMB, *President*
Woman's Auxiliary to the Indianapolis (Marion County) Medical Society.

OFFICIAL CALL TO THE HOUSE OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at Indianapolis, October 29, 30, and 31, 1946.

The House of Delegates will be constituted as follows: Marion County, sixteen delegates; Lake County, five delegates; Allen County, four delegates; St. Joseph County, three delegates; Vanderburg County, three delegates; Daviess-Martin, Dearborn-Ohio, Delaware-Blackford, Elkhart, Fayette-Franklin, Fountain-Warren, Jasper-Newton, Madison, Parke-Vermillion, Tippecanoe, Vigo, and Wayne-Union County societies, each two delegates; the other sixty-six county societies, each one delegate; thirteen councilors; and the ex-presidents, namely: C. S. Bond, W. H. Stemm, W. R. Davidson, E. M. Shanklin, Charles N. Combs, George R. Daniels, Charles E. Gillespie, A. B. Graham, F. S. Crockett, J. H. Weinstein, E. E. Padgett, R. L. Sensenich, Herman M. Baker, E. M. Van Buskirk, Karl R. Ruddell, A. M. Mitchell, M. A. Austin, Carl M. McCaskey, J. T. Oliphant, and N. K. Forster. In addition to these, the president, secretary, and treasurer, all without power to vote except in case of a tie, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to Ray E. Smith, 1021 Hume Mansur Building, Indianapolis 4, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 4:00 P.M., Tuesday, October 29, in the Murat Theater, Indianapolis, and again at 7:15 o'clock, Thursday morning, October 31, in the Chateau Room of the Claypool Hotel. (Breakfast meeting.)

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Report of executive secretary.
6. Report of the treasurer.
7. Report of the chairman of the council.
8. Reports of standing and special committees:
   - (1) Credentials.
   - (2) Executive Committee.
   - (3) Arrangements.
   - (4) Scientific Work.
   - (5) Public Policy and Legislation.
   - (6) Bureau of Publicity.
   - (7) Civic and Industrial Relations.
   - (8) Medical Education and Hospitals.
   - (9) Council on Medical Service and Public Relations.
   - (10) Journal Publication.
   - (11) Secretaries' Conference.
   - (12) Scientific Exhibit.
   - (13) Necrology and History.
   - (14) Physical Fitness.
   - (15) Mental Health.
   - (16) Study of Lay Activity in Medical Practice.
   - (17) Advisory Committee to the Bureau of Maternal and Child Health of the Indiana State Board of Health.
   - (18) Liaison Committee of the Division of Services for Crippled Children.
   - (19) Auditing.
   - (20) Control of Cancer.
   - (21) Venereal Disease.
   - (22) Industrial Health.
   - (23) Indiana Inter-professional Health Council.
   - (24) Anti-Tuberculosis.
   - (25) Conservation of Vision.
   - (26) Postwar.
   - (27) Physical Therapy.
   - (28) Medical Relief.
   - (29) Rural Medical Care.
   - (30) Hard of Hearing.
   - (31) Postwar Medical Service.
   - (32) Medical Economics.
   - (33) Medical Advisory Committee for Vocational Rehabilitation.
   - (34) Centennial Celebration.
   - (35) Building.
   - (36) Establishment of Board of Certification for the General Practice of Medicine.
   - (37) Veterans' Affairs Committee.
   - (38) State Fair.
   - (39) Veterans' Care Committee.
   - (40) Prevention of Traffic Accidents.
   - (41) Revision of the Constitution.
9. Reading of communications.
10. Reading of memorials and resolutions.
11. Unfinished business.
12. New business.
13. Adjournment.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1946, and their successors must be elected at the session: Delegates to the American Medical Association to succeed H. G. Hamer, Indianapolis, and A. S. Giordano, South Bend; and alternates, Karl R. Ruddell, Indianapolis, and George Collett, Crawfordsville.

Delegates from the third, sixth, ninth, and twelfth districts are reminded that the terms of their councilors will expire December 31, 1946, and new councilors should be elected to succeed the following:

Third District: A. P. Hauss, New Albany.
Sixth District: W. U. Kennedy, New Castle.
Ninth District: Wemple Dodds, Crawfordsville.
Twelfth District: A. Jerome Sparks, Ft. Wayne.

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

Attention is called to the fact that Dr. H. C. Wadsworth, councilor of the Second District, resigned November, 1945, and that Dr. J. H. Crowder was elected by the House of Delegates to fill Dr. Wadsworth's unexpired term, ending December 31, 1945. The Second District Medical Society met June 5, 1946, but held no election.

RAY E. SMITH,
Executive Secretary.

Reports of Officers and Committees

EXECUTIVE SECRETARY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Having stepped into Tommy Hendricks' shoes only last May 1, your present executive secretary and managing editor of THE JOURNAL has no glowing report of world-shattering accomplishments for your honorable body. He cannot "point with pride at the record," as the political orators always do, for the simple reason that there isn't any. Figuratively speaking, Tommy left a very large pair of shoes to be filled, and up to now your executive secretary has been trying to familiarize himself with the way Tommy handled the association's affairs so ably.

In acquainting himself with his duties, the undersigned has received valuable guidance and counsel from his predecessor. With Tommy now "up" in the "major league" of medicine, this advice will be greatly missed. However, as "Executive Secretary Emeritus," Tommy is still Indiana's own. His multitude of friends in the state expect him to come back often and shower them with his genial personality and his effervescent sense of humor.

The writer attended the following nine district meetings: First district at Evansville, Third district at Spring Mill State Park, Fourth district at Columbus, Fifth district at Terre Haute, Sixth district at Brookville, Seventh district at Indianapolis, Eighth district at Muncie, Eleventh district at Peru, and the Twelfth district at Fort Wayne. In addition he has been present at a number of county medical society meetings and several Woman's Auxiliary sessions. This policy of attending district and county meetings—as many as time permits—will be continued. In order to keep abreast with medical organization activities, on state and national levels, he attended the A.M.A. House of Delegates meetings in Chicago and San Francisco, the editors' and secretaries' conference at the A.M.A. headquarters in Chicago, the National Conference on Medical Service in Chicago, and the centennial convention of the Ohio State Medical Association at Columbus.

In addition to preparing news releases for daily and weekly newspapers, time was spent on business affairs of THE JOURNAL. In the future the executive secretary hopes to accept more responsibility in THE JOURNAL management.

Efforts will be made by your executive secretary to build a strong, united and hard-hitting state organization for advancing the cause of medicine and defending it against those who would destroy or weaken it. This cannot be done without the co-operation of every member of the association, and this co-operation is most earnestly solicited.

The executive secretary and the state headquarters staff are ready to serve you. We are glad for the opportunity to serve each individual physician—and we mean it! Call on us whenever we can be of help. We are always glad to have you drop in the office on business or for a friendly chat.

It has been a pleasure to work with the medical profession of Indiana, and I wish to take this opportunity to express my gratitude for the many kindnesses I. S. M. A. members have shown me. I shall try my best to merit the confidence which you have placed in me.

RAY E. SMITH,
Executive Secretary.

TREASURER

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The accompanying report prepared by certified public accountants gives our financial statement for the period ending December 31, 1945.

During the past year there has been no change in the amount of our permanent holdings.

While we show a modest gain of income, we hope, with the return of our service group, to make a more substantial gain the coming year.

The following report has been prepared by the Geo. S. Olive & Co.:

January 11, 1946.

The Council,
Indiana State Medical Association.

Gentlemen:

We have examined the cash records of your Association for the year ended December 31, 1945.

This examination was undertaken for the purpose of determining and verifying the cash transactions for the year, and of verifying the assets and liabilities at the close of the year, as recorded on the records.

The results of our examination are presented in this report, which includes: (1) text of comments; (2) statement of assets of all funds at December 31, 1945; (3) statements of receipts and disbursements of all funds, year ended December 31, 1945. A list of the statements is presented on the first page following this text.

GENERAL COMMENT

In Exhibit A is presented an analysis of the increase in assets of the Association for the year ended December 31, 1945, showing in summary form the sources from which this increase was derived.

The increase of $6,705.98 is attributable to an excess of operating cash receipts over operating cash disbursements of the General Fund, THE JOURNAL of the Indiana State Medical Association, and the Medical Defense Fund.

During the period under review, a $2,000 loan was repaid to the Medical Defense Fund from the General Fund. A similar loan of $3,000 due the Medical Defense Fund from THE JOURNAL of The Indiana State Medical Association has been cleared by permanent transfer to THE JOURNAL account.

Details of the assets of all funds are presented in Exhibit B. There were no recorded liabilities at December 31, 1945, and the assets shown represent the surplus of each fund at that date. We have examined securities of the Association, and confirmed bank balances by direct correspondence with the depositories.

Details of the cash receipts and disbursements of the General Fund, of THE JOURNAL of the Indiana State Medical Association, and of the Medical Defense Fund are presented in Exhibits C, D and E.

Yours very truly,

GEO. S. OLIVE & CO.,
Certified Public Accountants.

Indiana State Medical Association

LIST OF STATEMENTS CONTAINED IN REPORT ON EXAMINATION OF CASH RECORDS, YEAR ENDED DECEMBER 31, 1945

Exhibit A—Analysis of increase in assets, all funds, year ended December 31, 1945.

Exhibit B—Statement of assets, all funds at December 31, 1945.

Exhibit C—Comparative statement of cash receipts and disbursements, years ended December 31, 1944, and December 31, 1945.

Exhibit D—Statement of cash receipts and disbursements of THE JOURNAL of the Indiana State Medical Association, year ended December 31, 1945.

Exhibit E—Statement of cash receipts and disbursements of the Medical Defense Fund, year ended December 31, 1945.

EXHIBIT A

Indiana State Medical Association

ANALYSIS OF INCREASE IN ASSETS, ALL FUNDS, YEAR ENDED DECEMBER 31, 1945

TOTAL ASSETS, DECEMBER 31, 1945—Exhibit B		$51,797.93
TOTAL ASSETS, DECEMBER 31, 1944		45,091.95
NET INCREASE		$ 6,705.98
Arising from the following sources:		
Excess of operating cash receipts over operating cash disbursements, General Fund, year ended December 31, 1945:		
Receipts—Exhibit C	$42,188.98	
Disbursements—Exhibit C	39,625.97	
	$ 2,563.01	
Less: Repayment of loan to Medical Defense Fund	2,000.00	
		$ 563.01
Excess of operating cash receipts over operating cash disbursements, THE JOURNAL of the Indiana State Medical Association, year ended December 31, 1945:		
Receipts—Exhibit D	$29,336.87	
Disbursements—Exhibit D	26,167.90	
		3,168.97
Excess of operating cash receipts over operating cash disbursements, Medical Defense Fund, year ended December 31, 1945:		
Receipts—Exhibit E	$ 2,789.00	
Disbursements—Exhibit E	1,815.00	
	$ 974.00	
Add: Receipt of repayment of loan from General Fund	2,000.00	
		2,974.00
TOTAL NET INCREASE		$ 6,705.98

EXHIBIT B

Indiana State Medical Association

STATEMENT OF ASSETS, ALL FUNDS, AT DECEMBER 31, 1945

General Fund:		
Cash on deposit—Exhibit C		$ 1,028.92
Petty cash fund		200.00
Investments:		
Marion County Flood Prevention bonds	$ 3,000.00	
Indianapolis City Hospital bonds	5,000.00	
U. S. Treasury bonds	13,000.00	
U. S. Savings bonds	5,000.00	
		26,000.00
Total General Fund		$27,228.92
THE JOURNAL of the Indiana State Medical Association:		
Cash on deposit—Exhibit D		$ 6,063.29
Total JOURNAL assets		6,063.29
Medical Defense Fund:		
Cash on deposit—Exhibit E		$ 3,505.72
Investments:		
Marion County Flood Prevention bonds	$ 2,000.00	

U. S. Treasury bonds	5,000.00	
U. S. Savings bonds	5,000.00	
U. S. Baby bonds	3,000.00	
		15,000.00
Total Medical Defense Fund		18,505.72
Total Assets, All Funds—Exhibit A		$51,797.93

EXHIBIT C

Indiana State Medical Association

COMPARATIVE STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEARS ENDED DECEMBER 31, 1945, AND DECEMBER 31, 1944

	Year Ended December 31, 1945	December 31,1944	Increase Decrease
CASH BALANCE AT BEGINNING OF YEAR	$ 465.91	$ 5,131.81	**$ 4,665.90**
Receipts:			
Membership dues	33,603.00	23,288.50	10,314.50
Income from exhibits	5,695.00	7,575.00	**1,880.00**
Petty cash refund—contra	500.00	.....	500.00
Miscellaneous refunds	56.02	3.30	52.72
Interest income:			
U. S. Treasury bonds	368.75	368.75	.....
U. S. Savings bonds	125.00	125.00	.....
Indianapolis, Indiana, City Hospital bonds	200.00	200.00	.....
Marion County, Indiana, Flood Prevention bonds	127.50	127.50	.....
Instruction courses — annual session	.....	145.00	**145.00**
Refund on convention expense	69.56	193.72	**124.16**
Industrial health conference	.....	60.00	**60.00**
Funds transferred from Medical Defense Fund	.....	2,000.00	**2,000.00**
Reimbursements from American Medical Association	194.15	.....	194.15
Check for Dunninger fee	1,250.00	.....	1,250.00
	$42,188.98	$34,086.77	$ 8,102.21
BEGINNING BALANCE PLUS CASH RECEIPTS	$42,654.89	$39,218.58	$ 3,436.31
Disbursements:			
Transfer of applicable portion of dues to THE JOURNAL of the Indiana State Medical Association — Exhibit D	$ 6,726.00	$ 6,768.00	$ **42.00**
Medical Defense Fund — Exhibit E	2,439.00	2,460.00	**21.00**
Headquarters' office expense	11,384.80	12,564.95	**1,180.15**
Publicity committee	2,476.37	2,051.00	425.37
Public policy	1,403.74	283.27	1,120.47
Council	6,267.24	6,241.36	25.88
Officers	496.75	313.39	183.36
Annual session	4,750.98	4,957.20	**206.22**
Miscellaneous committees	2,353.95	2,882.11	**528.16**
Federal Old Age Benefit Tax	93.39	76.39	17.00
Refund of dues	36.75	30.00	6.75
Petty cash refund—contra	500.00	.....	500.00
National Conference on Medical Service expense	147.59	.....	147.59
Refund of exhibit rent	340.00	.....	340.00
Other refunds	.....	25.00	**25.00**
Instructional course expense	.....	100.00	**100.00**
Payments for American Medical Association	194.15	.....	194.15
Miscellaneous expense	15.26	.....	15.26
Funds transferred to Medical Defense Fund	2,000.00	.....	2,000.00
	$41,625.97	$38,752.67	$ 2,873.30
CASH BALANCE AT END OF YEAR	$ 1,028.92	$ 465.91	$ 563.01

EXHIBIT D

Indiana State Medical Association

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEAR ENDED DECEMBER 31, 1945

THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

BALANCE, JANUARY 1, 1945		$ 2,894.32
Receipts:		
Subscriptions—members—Exhibit C	$ 6,726.00	
Subscriptions—non-members	461.92	
Advertising	21,985.45	
Collection on accounts receivable	47.00	
Single copy sales	50.85	
Electrotypes	65.65	
Total receipts—Exhibit A		29,336.87
		$32,231.19
Disbursements:		
Salaries	$10,498.47	
Printing	12,042.36	
Office postage	333.42	
Journal postage	501.14	
Press clippings	68.10	
Telephone and telegraph	257.97	
Electrotypes	737.80	
Office rent and electricity	515.93	
Office supplies	575.61	
Advertising commissions and reporting	546.14	
Federal Old Age Benefits Tax	75.30	
Miscellaneous	15.66	
Total disbursements—Exhibit		26,167.90
BALANCE, DECEMBER 31, 1945—EXHIBIT B		$ 6,063.29

EXHIBIT E

Indiana State Medical Association

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, YEAR ENDED DECEMBER 31, 1945

MEDICAL DEFENSE FUND

BALANCE, JANUARY 1, 1945		$ 531.72
Receipts:		
Transfer of applicable portion of dues from the General Fund—Exhibit C	$ 2,439.00	
Interest income:		
U. S. Treasury bonds	140.00	
U. S. Savings bonds	125.00	
Marion County Flood Prevention bonds	85.00	
Funds transferred from General Fund	2,000.00	
Total receipts—Exhibit A		4,789.00
		$ 5,320.72
Disbursements:		
Attorney's fee	$ 1,800.00	
Treasurer's bond	15.00	
Total disbursements—Exhibit A		1,815.00
BALANCE DECEMBER 31, 1945—Exhibit B		$ 3,505.72

A. F. WEYERBACHER, M.D.,
Treasurer.

CHAIRMAN OF THE COUNCIL

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Since the 1945 report five regular and two special meetings of the Council have been held. Because there have been so many meetings, and the additional fact that minutes of all sessions have been printed in THE JOURNAL, only a briefing of the Council's actions seems advisable.

Attendance at the Council meetings has been gratifying. The members have deliberated thoughtfully upon the many grave problems that have come before them. They have been conscious at all times of their heavy responsibilities to Hoosier medicine, and their fidelity to duty is reflected in the sound wisdom of their decisions.

I wish to express my heartfelt appreciation to the Council members for the courtesy and cooperation accorded me as their presiding officer.

FIRST MEETING, FRENCH LICK, NOVEMBER 6, 1945

With F. T. Romberger of Lafayette, chairman, presiding, the Council accepted the resignation of George Dillinger as a delegate to the A.M.A. House of Delegates and H. C. Wadsworth as Councilor of the Second District.

The five dollars war assessment upon each member in the state association was terminated, beginning in 1947.

Thomas A. Hendricks and Ray E. Smith were continued as executive secretary and assistant executive secretary respectively for another year, each on a half-time basis.

The Council recommended an amendment to the by-laws requiring that it meet four times a year instead of twice.

E. M. Shanklin was re-elected editor of THE JOURNAL.

The Council approved the recommendation of Executive Committee that THE JOURNAL be allowed to retain $3,000 loaned to it.

Floyd T. Romberger had resigned as a member of the Council to become eligible for election as president-elect. A. M. Mitchell was elected chairman pro tem and presided at the meeting.

W. U. Kennedy, W. H. Howard and W. L. Portteus were named members of a committee to draw up plans for organization of a stock company and a mutual type company which would write prepayment medical care insurance.

SPECIAL MEETING, INDIANAPOLIS, DECEMBER 16, 1945

E. M. Shanklin, editor of THE JOURNAL, reported that the overall mechanical costs for producing the publication would be sixty per cent higher beginning in 1946.

A resolution was adopted which asked that the Indiana State Board of Medical Registration and Examination require each applicant for a certificate to practice osteopathy, medicine, surgery and obstetrics to have successfully passed an examination in materia medica in a medical school approved by the board before the applicant is admitted to examination before the board.

A proposed program drafted by ex-medical officers and referred to the Council by the House of Delegates was taken up paragraph by paragraph. Approved by the Council was the suggestion that service men hold an official luncheon at each annual session, and that loans to doctor veterans be arranged.

An agency-type indemnity plan for offering prepayment medical care insurance in Indiana was approved for recommendation to the House of Delegates.

MIDWINTER MEETING, INDIANAPOLIS, JANUARY 13, 1946

A report of the accounting firm of Geo. S. Olive & Co. read revealed total assets as of December 31, 1945 of $51,797.93, a gain of $6,705.98 over the previous year.

Due to insufficient hotel accommodations in Fort Wayne, the 1946 annual session was moved to Indianapolis.

After due consideration a motion was adopted placing the Council on record as favoring the mutual indemnity plan, non-profit, instead of the agency type when the prepayment medical care insurance company is organized.

E. H. Clauser was named chairman, and A. P. Hauss a member of the Inter-Professional Health Council for 1946.

Appointment of a committee to confer with the Indianapolis Medical Society regarding whether the state association might go in with it on erecting a home was authorized.

Appointment of a Committee on Revision of the Constitution was approved.

Pierce MacKenzie was nominated for the Editorial Board.

Cleon A. Nafe and Carl H. McCaskey were re-elected members of the Executive Committee for 1946.

A. M. Mitchell was elected chairman of the Council for 1946.

SPECIAL MEETING, INDIANAPOLIS, JANUARY 27, 1946

Members of the Council were designated by motion as the incorporators of the Mutual Medical Insurance Co., Inc., which was authorized by the House of Delegates at a meeting on this date, plus the following: M. A. Austin (later declined to serve), F. S. Crockett, J. E. Ferrell, M. R. Lohman, Walter L. Portteus and F. T. Romberger. W. U Kennedy was named temporary chairman of the board of directors of the company. A. F. Weyerbacher was named to hold the funds contributed to the company pending election of a treasurer.

Appointment of a Committee for Medical Care of Veterans was authorized. The committee was directed to confer with General Paul R. Hawley about an arrangement with the Veterans Administration whereby service-connected cases could be treated by private physicians.

SPRING MEETING, INDIANAPOLIS, APRIL 14, 1946

Headquarters office was directed to arrange a

sightseeing train tour to A.M.A. meeting in San Francisco.

N. K. Forster elected associate editor of THE JOURNAL.

Stamp of approval given Advisory Committee to the Co-operative Medical Advertising Bureau of the A.M.A.

The resignation of Thomas A. Hendricks as executive secretary and managing editor of THE JOURNAL so that he could devote his full time to the Council on Medical Service of the American Medical Association was accepted.

Mr. Hendricks was voted the honorary title of "Executive Secretary Emeritus" by the Council.

Ray E. Smith was engaged as executive secretary and managing editor of THE JOURNAL to succeed Mr. Hendricks, effective May 1, 1946, and Miss Lucille Kribs was reinstated as assistant executive secretary as of that date.

A fee schedule and agreement for treatment of veterans by private physicians was approved and the Committee for Medical Care of Veterans was directed to send it to the Veterans Administration at Washington, D.C., for acceptance.

Majority report of Committee to Study Cancer Clinic Situation, which recommended that tumor clinics conform to standards set by the American Medical Association and the American Cancer Society, and that none be established without county medical society approval, was accepted.

Council voted a charter to the Owen-Monroe Medical Society.

SUMMER MEETING, INDIANAPOLIS, JULY 21, 1946

Committee composed of C. J. Clark, chairman; Alfred Ellison, A. P. Hauss and E. H. Clauser, named to study the nurse shortage problem and make recommendations for a solution.

JOURNAL editor announced plans for "Year Book" edition and adoption of a platform for the publication.

Sending letter of appreciation to Willis D. Gatch, who recently resigned as dean of the Indiana University School of Medicine, for his co-operation was authorized.

Survey of child health services sponsored by the American Academy of Pediatrics is approved for Indiana.

Merger of Brown County with Bartholomew County Medical Society, to be known as the Bartholomew-Brown County Medical Society, approved.

Lall Montgomery nominated for Editorial Board of THE JOURNAL.

Motion adopted requesting management of Indiana State Fair to refuse concession privileges to medical fakers who peddle patent medicines during the annual exhibition.

H. G. Hamer reported on A.M.A. House of Delegates sessions in San Francisco.

State Board of Health tuberculosis control program outlined by L. E. Burney, state health commissioner.

Respectfully submitted,
A. M. MITCHELL, M.D., *Chairman.*

REPORTS FROM DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

A joint meeting of the First District Medical Society and the Vanderburgh County Medical Society was held on May 14, 1946, at the Hotel McCurdy, in Evansville. The meeting was in the charge of Dr. Austin Marchand and Dr. C. A. Hartley, Jr. The following new officers for the First District were elected: president, Dr. William Cockrum, Evansville; vice-president, Dr. George W. Willison, Evansville; secretary-treasurer, Dr. Virgil McCarty, Princeton. Dr. I. C. Barclay, Evansville, is councilor to the Indiana State Medical Association.

Dr. J. E. Ferrell, Fortville, president of the Indiana State Medical Association, was the first speaker. He discussed several problems confronting physicians today.

Dr. J. Grey Jones, St. Louis, spoke on "Diagnosis and Treatment of Chronic Pelvic Inflammation."

Mr. Ray Smith, Indianapolis, new executive secretary of the Indiana State Medical Association, spoke briefly.

I. C. BARCLAY, M.D., *Councilor.*

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SECOND COUNCILOR DISTRICT

The Owen-Monroe County Medical Societies asked to be consolidated during the year, and this was allowed.

The medical societies of this district have been handicapped by the limited number of doctors available. With the increased number of returning physicians, the district looks forward to a more active year during 1947.

The Second Councilor District medical meeting was held June fifth, at the Sullivan Hotel, with the Sullivan County Medical Society as host. There were thirty-five members in attendance, but since all counties were not represented it was decided to renominate the present officers: Dr. K. L. Hull, of Bloomfield, president; and Dr. J. S. Brown, of Carlisle, secretary. No action was taken on the election of a councilor.

J. H. CROWDER, M.D., *Councilor.*

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THIRD COUNCILOR DISTRICT

The first post-war meeting of the Third District Medical Society was held at the Spring Mill State Park, May twenty-second.

The Lawrence County Medical Society was the host at the meeting, with Dr. Claude Dollens, Oolitic, presiding as president, and Dr. Roland E. Wynne, Bedford, as secretary.

Dr. W. U. Kennedy, New Castle, very ably discussed the threat of state medicine and Indiana's prepaid medical insurance plan. Dr. John Warvel's (of Indianapolis) lecture on "Diabetes" was

actually a masterpiece. Mr. Ray E. Smith, Indianapolis, executive secretary of our state association, made his initial bow to the district society, and in a few modest but well-chosen words impressed us with the fact that he was on the job and a worthy successor to Tommy Hendricks. The district councilor also made his annual report to the district.

The meeting was well attended, the food and accommodations were excellent, and much interest and enthusiasm was shown. Dr. P. R. Pierson, New Albany, was elected president, and Dr. William F. Edwards, New Albany, secretary for 1947. Dr. Augustus P. Hauss was re-elected councilor. The district will hold its next annual meeting at New Albany in May.

This report would not be complete without paying tribute to the splendid war record of the physicians of the Third District in the service and on the home front. Most all the men are now back home, several new physicians have located in our counties, and there are now more physicians in the district than before the war. There is considerable post-war planning among the doctors in the nine counties. Washington County is to have a new hospital, at Salem, and new hospitals or additions are being considered in several other counties. Many of the doctors have new offices with improved clinical facilities and equipment. At least five of the nine counties are planning full-time health departments for 1947, in conjunction with the State Board of Health extension plan. There is definitely improved cooperation and fellowship and increased interest in medical organization among the physicians of the Third District. This all summed up means that down in the hills of southern Indiana the doctors are doing their job.

AUGUSTUS P. HAUSS, M.D., *Councilor.*

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FOURTH COUNCILOR DISTRICT

The Fourth Councilor District of the Indiana State Medical Association met at Columbus on May 29, 1946. There was a marked increase in the number attending and in the interest manifested. It was encouraging to see a desire for sociability and play again entering into meetings. There was an invitation to play golf in the morning and a banquet was held in the evening; both had been discontinued throughout the war years. The program was instructive and entertaining. The place of the meeting for next year will be Seymour. The following officers were elected: president, Dr. L. H. Osterman, Seymour; vice-president, Dr. George S. Row, Osgood; secretary-treasurer, Dr. H. P. Graessle, Seymour.

CHARLES F. OVERPECK, M.D., *Councilor.*

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FIFTH COUNCILOR DISTRICT

All member societies of the Fifth District Medical Society are functioning. A district meeting was held at Terre Haute on June 5, 1946. The speakers were Dr. Jacob Berman, Dr. Clyde Culbertson, and Dr. C. J. Clark, all of Indianapolis; Mr. Ray Smith, executive secretary of the Indiana State Medical Association; and Dr. Floyd Romberger, president-elect of the Indiana State Medical Association.

A. M. MITCHELL, M.D., *Councilor.*

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SIXTH COUNCILOR DISTRICT

The return of those who have been in the service is practically complete. Reports from various sources indicate that little trouble has been experienced in rebuilding practices.

Renewed interest in both professional and economic matters is evidenced by the increased activity in each of the component societies.

The Wayne County Medical Society had the unique privilege of a dinner in honor of three members of ninety or more years.

The district meeting at Brookville consisted of a fine program, and the local men arranged the usual feast of unlimited chicken. The state president, who belongs to our district, presented an informative review of present and future activities of the association.

Dr. Will Thompson, the district president, who presided, is entitled to much credit for this meeting.

The district president and the councilor have carried out a policy of visitation to each of the societies, and intend continuing to do so.

The district as a whole has made substantial contributions to the Medical Care Insurance Fund, evidencing their desire to support the association policies against socialized medicine.

Dr. W. U. Kennedy, of New Castle, was re-elected councilor.

W. U. KENNEDY, M.D., *Councilor.*

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SEVENTH COUNCILOR DISTRICT

The past year has seen most of our general practitioners returned from military service. A great many of them are confronted by the almost impossible task of finding homes and offices. In this district the situation has been especially acute. The problem has been met partly by the willingness to share offices and even homes. In other cases doctors have helped find space for the less fortunate.

The Seventh District meeting which will be at Danville probably will be held early in December. A definite date will be announced later.

C. J. CLARK, M.D., *Councilor.*

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EIGHTH COUNCILOR DISTRICT

The annual meeting of the Eighth District Medical Society was held at the Delaware County Country Club, on June 12, 1946. Dr. B. W. Stocking, president, was in charge of the meeting. Dr.

David Boyd, of Indianapolis, read a paper entitled "A General Survey of Psychosomatic Medicine."

A report was made by the councilor. The subject of responsibility of hospitals to the patient was discussed.

Mr. Ray Smith reported recent activities of the state office.

Officers elected for the coming year were: Dr. F. E. Keeling, Portland, president; Dr. Frederick Streib, Redkey, secretary-treasurer; Dr. E. H. Clauser, Muncie, re-elected councilor.

The 1947 meeting will be held at Portland.

DR. E. H. CLAUSER, *Councilor.*

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NINTH COUNCILOR DISTRICT

The annual meeting of the Ninth Councilor District was held at the Ulen Country Club, at Lebanon, on May 7, 1946.

Our host, the Boone County Medical Society, "strutted its stuff" and put on a most enjoyable and profitable program. The first post-war golf tournament was held in the morning, and there were twenty-one participants.

A splendid scientific program was presented in the afternoon, with President Weddle presiding. A symposium on "Penicillin" was given. Mr. G. E. Hines, of Terre Haute, discussed "Production of Penicillin." Drs. Brandt F. Steele, Robert D. Howell, and Russell L. Arbuckle, all of Indianapolis, discussed the clinical use of penicillin in their respective fields.

A fine dinner was served in the evening to 125 members and guests. Mr. Allen Saunders, of Toledo, Ohio, was the speaker, and his subject "Philosophy of Humor" provoked a great deal of merriment as he analyzed humor and explained how it had become big business.

Dr. Wemple Dodds, of Crawfordsville, was elected to succeed himself for a period of three years after serving out the unexpired term of Dr. Floyd T. Romberger, who became president-elect of the Indiana State Medical Association at the French Lick meeting.

The Fountain-Warren County Medical Society is to be host of the Ninth Councilor District meeting in 1947.

WEMPLE DODDS, M.D., *Councilor.*

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TENTH COUNCILOR DISTRICT

The Tenth District Medical Society of the Indiana State Medical Association, led by Dr. L. J. Danieleski, president, and Dr. M. B. Gevirtz, secretary, sponsored a meeting on October 24, 1945, in conjunction with the Gardiner General Hospital, in Chicago. Members of the district were guests of Colonel John M. Hall, M.C., the commanding officer. The meeting began with an inspection of the hospital, followed by a dinner and entertainment for the doctors' wives who were present.

In the evening a splendid scientific program was presented by Lieutenant Colonel George Plain, M.C., chief of Surgical Services, whose subject was "Management of Chronic Osteomyelitis, Secondary to Compound Fractures." He was assisted by Major Fred C. Reynolds, M.C. and Captain Charles E. Stebbins, M.C. Actual cases were presented for examination relative to the subjects discussed. Added to the scientific program were interesting personal pictures presented by Brigadier General J. M. McCoy, who was making a routine inspection of the hospital. A very pleasant and instructive evening was enjoyed by the doctors and their wives.

The spring meeting of the district was combined with the Northern Tri-State Medical Association meeting at South Bend, on Tuesday, April ninth.

An election was held on May ninth at the Indiana University Extension Center, East Chicago. Dr. George M. Cook, of Hammond, was elected president, and Dr. A. C. Remich, of Hammond, was elected secretary for the year 1946-47.

WILLIAM H. HOWARD, M.D., *Councilor.*

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ELEVENTH COUNCILOR DISTRICT

Reporting on "the state of the Eleventh District," we beg to say that our district still ranks first in the state.

As to comparative membership:

County	*1944*	*1945*	*1946*
Carroll	7	7	11
Cass	28	29	37
Grant	37	30	48
Howard	23	24	31
Huntington	16	16	21
Miami	19	22	20
Wabash	17	21	24
Total	147	149	192

We had a splendid meeting at Peru, on May 15, 1946. This was reported in the June JOURNAL. It was the first time since World War II began that we have had an evening program. This proved to be a good meeting, but was not well attended.

We noted with considerable interest and misgiving why so few of the doctors who have returned from service attended this meeting.

We are now building our program for our next meeting, which will be held in the Veterans' Hospital, in Marion, September 18, 1946, having in mind these younger men. Each county is urged to announce this meeting, and to do all possible to get a good attendance. The Marion meeting will be "an old-fashioned one," in that we shall have a forenoon clinic, an afternoon scientific session, and an evening dinner and program, all to be held at the Veterans' Hospital.

In accordance with the unanimous vote of the men present at the Peru meeting, our treasurer has invested $250 in the Mutual Medical Care, Inc.,

and now holds a certificate in that amount. We also have on hand, and all bills paid, about $145.

The doctors who have been in service have practically all returned and are getting back into practice. We welcome these men back into our ranks.

C. S. Black, M.D., *Councilor.*

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TWELFTH COUNCILOR DISTRICT

The Twelfth District will have a new representation in the Council, beginning in 1947. My congratulations to him on his election.

The councilor's job nowadays consumes a great deal of time and carries considerable responsibility, for the Council, together with the officers, influence the policies of the state association. And only those who have been really active in state affairs during the past several years realize what hectic times these were and will continue to be.

The principal cause for the upheaval is the demand for a change in the economic phase of medical practice. While none of us relish radical changes, many were smart enough to realize that certain changes were inevitable and fought for them at every opportunity. That we were on the beam was finally proved by recent action of the House of Delegates of the American Medical Association.

Additional concessions will have to be made—many of them radical, to our way of thinking. However, what changes will take place can be brought about to our satisfaction, with ourselves in control, if we present a united front in our actions. For the most part, the responsibility for bringing this about lies with the officers and the councilors of the state association.

A. Jerome Sparks, M.D., *Councilor.*

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THIRTEENTH COUNCILOR DISTRICT

The Thirteenth District continues to function as in the past several years. Kosciusko County continues to have difficulty with organization, but it is hoped that with the return of men from the service an active society will now be re-established.

Our annual meeting will be held in Elkhart, all day Wednesday, November thirteenth. A clinic will be held in the forenoon, and three speakers will address the society in the afternoon. Following the dinner we will be addressed by an outstanding member of our profession on some sociologic or economic phase of our profession. We are hoping also to have some of our state officials as our guests.

We cordially invite you to join with us in Elkhart, on November thirteenth.

Alfred Ellison, M.D., *Councilor.*

COMMITTEE ON CREDENTIALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Credentials served in its official capacity three times during the past year, that is, at the regular meetings of the House of Delegates which were held at French Lick on November 6 and 8, 1945, during the annual session, and at the special meeting of the House of Delegates on January 27, 1946, at Indianapolis.

In accordance with the Constitution and By-Laws of the Indiana State Medical Association, each county medical society must certify its delegates and alternates previous to the annual session. A postal card notification, signed by the secretary of the local county medical society and sent to the headquarters office, is sufficient certification. If you have not yet taken this action in your society, we urge that this be done immediately.

W. E. Amy, M.D., *Chairman,*
Hugh S. Ramsey, M.D.,
Parvin M. Davis, M.D.,
T. A. Dykhuizen, M.D.,
George N. Love, M.D.

EXECUTIVE COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

INTRODUCTION

During the year the Executive Committee spent long hours at its regular meetings and held numerous informal conferences on many of the problems which concern our medical association. Many of these problems have been studied by other committees and officers. We suggest that you carefully study their reports. We are here giving a summary of many of these activities as they have been presented to the Executive Committee, in order that the doctors of Indiana may have a more complete understanding of the accomplishments of 1946 and the problems of 1947.

The period from August 1, 1945, to August 1, 1946, was predominately a year of readjustment within the medical profession of Indiana. Hundreds of physicians laid their military clothing away in moth balls, refilled their medicine cases, and began the routine work of caring for their patients . . . overjoyed to be civilians again and back in the private practice of medicine.

For many of the returned doctors it was not this easy. Many had no patients and had to rebuild their entire practices. Some began the slow process of establishing themselves in new locations. Others returned to hospitals and classrooms to further their medical education.

As the doctor veterans reopened their offices,

physicians who had remained on the home front began to get badly needed rest. With each coming new day medical practice moves toward normalcy in Indiana. By the end of the year displacements and maladjustments in the profession will be almost negligible.

Strangely, while medics were writing a brilliant record on battlefields and home soil, a dark cloud threatening medicine gathered in the sky at Washington. At war's end the cloud grew blacker. It was the Wagner-Murray-Dingell bill that would finance a national health program by taking a sizable cut out of pay checks of workers and profits of employers. It would place a government straight jacket on private medical practice. The bill died in committee, but the black cloud still hangs in the sky, and it is Indiana medicine's most immediate concern.

HIGHLIGHTS OF THE YEAR

Out of a multiplicity of activities of the association during the year, the Executive Committee wishes to call the attention of the House of Delegates to ten incidents. In one respect, particularly, was this an epoch-making year. We refer to the organization of an insurance company for the purpose of offering prepayment medical care insurance to the people. The establishment of this corporation was undoubtedly a very progressive step in the field of medical economics. By its action your organization kept pace with the program of the American Medical Association, which must prove that better medical care is possible on a voluntary prepayment basis at less cost to the public than government-controlled compulsory health insurance.

1. *Organization of Mutual Medical Insurance, Inc.* After the House of Delegates authorized the formation of a non-profit mutual company to write medical care insurance at a special meeting on January 27, 1946, a company was incorporated and officers elected. More than seven hundred doctors advanced money to provide initial finances for the company to start business. It is offering its certificates in conjunction with those of Blue Cross and, for the time being, on a group basis only. The president of the company, Dr. W. U. Kennedy of New Castle, and many others have labored long and diligently to get this insurance company established, and Indiana medicine owes them a debt of gratitude.

2. *Wagner-Murray-Dingell Bill.* Death of the Wagner-Murray-Dingell bill in committee was a majority victory for organized medicine. Through the Committee on Public Policy and Legislation, the association did its full part in opposing this legislation, and is entitled to a share of the credit. While we are jubilant over our success, we dare not consider the fight as won. A new Wagner-Murray-Dingell bill is promised in the 80th Congress. Your Executive Committee pledges its continued support of our Committee on Public Policy and Legislation in this last-ditch fight to save private medicine from government regimentation.

3. *Indiana Board of General Practice of Medicine, Inc.* Authorized by the 1945 House of Delegates, a Board of Certification for the General Practice of Medicine became a reality in 1946. In establishing this board, our state received nationwide recognition through American Medical Association channels. The first two hundred members of the board will be classified as founders and are being accepted without examination. The purpose of the board is to encourage study, improve the practice and elevate the standards of general practice.

4. *Veterans' Care.* A plan was worked out with the Veterans Administration whereby ex-service men of World War II could be treated by private practitioners. A schedule of fees was adopted and sent to Washington for approval. The veterans will have free choice of physicians, and will save red tape and waiting for entrance into a veterans' hospital. In cases of emergency he may be hospitalized locally.

5. *Loans to veterans.* Arrangements were made whereby loans up to $500 at three per cent interest could be made to physicians in need of financial assistance upon their return from military service. In several instances such a loan has proved a godsend to a veteran. The money is provided by an Indianapolis bank and is underwritten by the association. Surprisingly few veterans have applied for loans, but the Executive Committee made money available, wanting to do all it could to help ex-service doctors get a start.

6. *Rural Medical Care Conference.* The work of the Committee on Rural Medical Care was especially outstanding. Working with Farm Bureau leaders, the Purdue School of Agriculture and the Indiana State Board of Health, a conference of farmers from all counties of the state was held at Purdue and the question of rural health gone into thoroughly. After a study of local health conditions, another conference will be held and a method of solution agreed upon. (See report of Committee on Rural Medical Care, page 546). This committee has done a splendid job and is deserving of commendation.

7. *National Conference on Medical Service.* Your association sponsored the meeting of the National Conference on Medical Service in Chicago on February 10. Attendance was large and the program was excellent. The chairman of your Executive Committee was secretary of the conference and was elected president for 1946-47. Tommy Hendricks and Ray Smith were of great service in preparing and carrying through the details of that conference. Their excellent services made the responsibility of the secretary a pleasure.

8. *Bureau of Publicity expansion.* A new type of news release, a weekly column on health subjects, was started by the Bureau of Publicity. Going to weekly newspapers only, it met with instant acceptance. More than ninety papers now run the column, entitled "Hints on Health." The bureau continued its radio program, releases to daily news-

papers and handling of requests for speakers. Members of the Bureau of Publicity are required to devote many hours a year to the bureau's affairs and should be recognized for their praiseworthy contribution to medicine.

9. *New State Medical Registration Board.* Mention is made of the fact that a new State Board of Medical Registration and Examination was appointed by Governor Gates. Composed of two old members and three new physicians, it is a good board and may be counted upon to uphold the standards of medicine. It should be said in behalf of the two doctors who were retired from the board that they performed their duties well and the profession appreciates their services on the board.

10. *Personnel Changes.* It was with a mixed feeling of regret to see him leave and happiness over his good fortune that we said good-by to Tommy Hendricks on May 1, 1946. For more than twenty-one years our executive secretary, Tommy did a swell job. As we had feared when we loaned Tommy to the A. M. A. on a part-time basis, the Council on Medical Service of the A. M. A. found him so valuable that they wished him to spend his full time with them. The Council, upon the recommendation of the Executive Committee, accepted Tommy's resignation as executive secretary as of May 1, 1946, and gave to him the title, "Executive Secretary Emeritus." The association was fortunate that the possibility of the change was foreseen. Ray E. Smith, who had served for almost a year as part-time assistant to Tommy and executive secretary of the Indianapolis Medical Society, was engaged as executive secretary. It was necessary to secure his release from the Indianapolis Medical Society, where Ray had done an outstanding job. The Indianapolis Medical Society released him reluctantly, with the understanding that Ray would aid its new secretary in every way in becoming oriented. Miss Lucille Kribs was continued in the capacity of assistant executive secretary.

While we have lost the intimate relationship of a valued executive secretary, his position at the A. M. A. is such that Tommy is of great value to our association in keeping us informed concerning many problems. Ray Smith has assumed the full responsibility of the office with the result that there has been no interruption in the efficiency of the headquarters office and the fine character of our JOURNAL. This is possible only because of the loyalty and efficiency of those employed in these two offices.

On April 14, the Council, upon the recommendation of the Executive Committee, increased the salaries of the employees in the headquarters and JOURNAL offices, in keeping with the general upward trend in wages and in recognition of their excellent services to the Indiana State Medical Association.

The editorial staff of THE JOURNAL was augmented by the addition of Dr. N. K. Forster of Hammond, who became associate editor.

The regular duties of the Executive Committee fall very generally under three classifications—administrative, operation of THE JOURNAL, and supervision of the medical defense fund. Each will be discussed separately.

ADMINISTRATIVE

1. The Executive Committee is a creation of the Council and functions for it when not in session. The Council has increased its meetings to four a year. In addition to its regular meetings, the Executive Committee has met regularly with the Council to report to them and be appraised of their desires concerning pressing problems. Members of many important committees, public health officials and representatives of various medical organizations met with the Executive Committee and discussed problems of great concern to the medical profession.

2. *Membership at record peak.* On August 1, 1946, the paid-up membership of the association was 3,406, the highest in history. With the return of doctors from military service, our membership will continue to show steady gains. This is a healthy condition and augurs well for the future of the association. Comparative figures follow:

Year	*Number of Physicians in Indiana*	*Regular Members*	*Honorary Members*	*Total Members*
1943	4,165	2,983*	110	3,093
1944	4,165	3,197**	129	3,326
1945	4,165	3,187***	142	3,329
1946	4,165	3,251****	155	3,406

* Includes 741 men in service who received membership gratis.

** Includes 936 men in service who received membership gratis.

*** Includes 1,019 men in service who received membership gratis.

**** Includes 831 men in service who received membership gratis.

3. *Instructional course committee.* The Executive Committee voted to recommend to the House of Delegates that the Committee on Scientific Work each year name a subcommittee to handle the instructional courses which are conducted during the annual session.

THE JOURNAL

Acting as the agent for the Council, the Executive Committee has supervised the management of THE JOURNAL.

Even though THE JOURNAL was shackled by war restrictions and a paper shortage, it completed 1945 with its second highest page average in its history. Although the reading pages were reduced some, so far as the reading material was concerned there was no reduction, for instead of curtailing, some of the material was set in smaller type, thus affording more reading in a minimum of space.

The sentiment of the physicians in the armed forces has been particularly reflected in their expression of appreciation for THE JOURNAL, whose

aim it has been to keep them informed of the whereabouts of their colleagues, give them a cross section of Indiana Medicine, and convey as much scientific information as circumstances would permit.

The upward trend of THE JOURNAL in general is shown in the following report:

JOURNAL pages printed in 1945 as compared with former years:

Year	Reading Pages	Per Cent Reading	Adv. Pages	Per Cent Adv.	Total Pages	Aver. Pages Per Issue
1940	736	59	506	41	1242	103.5
1941	728	59	506	41	1234	102.8
1942	752	61	488	39	1240	103.3
1943	736	59	516	41	1252	104.1
1944	758	56	588	44	1346	112.1
1945	580	44	754	56	1334	111.1

Printing

The printing contract was continued with C. E. Pauley & Company. Even with the sixty per cent increase in printing costs asked by C. E. Pauley & Company, that was the lowest bid received. Another increase of 16 per cent in composition charges became effective as of June first, to meet the new scale of wages in the printing trade, and the resulting increase in printing costs for THE JOURNAL will be approximately $7,000 per year, based on the number of pages printed last year. However, our estimated advertising revenue for 1946 totals $31,255.58, as compared with our advertising income of $22,032.45 for 1945, and we hope to be able to offset the increased printing costs without having to delve into the association's reserve.

Advertising

The average number of advertising pages per issue has increased steadily in spite of the fact that the Executive Committee and Editorial Board have held strictly to the rules and regulations of the Council on Pharmacy and Chemistry of the American Medical Association in its acceptance of advertising. Many questions concerning the acceptability of various types of advertising have been settled by the committee.

A comparison of advertising revenue for the first six months of 1946 with that of previous years is given, although we must bear in mind that some of this represents extra charge for color in advertisements, and also the increase in advertising rates which became effective as of the first of this year:

First six months	1943	1944	1945	1946
Bureau agency	$2,950.97	$3,487.58	$6,114.28	$ 8,459.62
Direct	2,347.75	2,507.32	2,766.18	4,295.43
Total	$5,298.72	$5,994.90	$8,880.46	$12,755.05

JOURNAL advertisers are active supporters of your organization, and it is largely because of these that we are able to increase the number of reading pages sent to you each month. Therefore the committee urges the members of the association to give advertisers in THE JOURNAL their undivided support. Assured support of advertisers means a steadily increasing number of advertisers.

Library

An increasing number of physicians is making use of the library in THE JOURNAL office. While the selection is necessarily limited, some valuable books are to be found on the shelves in the library. New books received are listed in THE JOURNAL each month. All members of the association are privileged to avail themselves of this service.

MEDICAL DEFENSE ACTIVITIES

1. *Malpractice cases.* A year ago, at the time of this report, August 1, 1945, the following fifteen cases were pending before the committee, seven of which were closed during the year, leaving eight cases still pending:

Case No. 200—Suit filed February 2, 1932. Pending.

Case No. 203—(Closed.) Suit filed August 22, 1934. Defendant deceased. Estate settled in 1942; claim not filed in estate; legally the cause of action is no longer enforceable.

Case No. 226—(Closed.) Suit filed November 5, 1938. Suit withdrawn and another filed January 16, 1939, including as defendant insurance company carrying bond on physician. Defendant's demurrer overruled; defendant answered in general denial; case venued. Case settled by insurance company, November 21, 1941.

Case No. 230—Suit filed November 18, 1939. Pending.

Case No. 232—(Closed.) Suit filed April 11, 1940. Case tried and settled for $1,200.00.

Case No. 239—(Closed.) Suit filed May 1, 1941. Case dismissed before it came to trial due to death of plaintiff. Expense, $100.00.

Case No. 241—Suit filed February 7, 1941. Pending.

Case No. 242—Suit filed January 28, 1942. Case venued January 10, 1944. Pending.

Case No. 243—(Closed.) Suit filed August 15, 1942. Suit withdrawn.

Case No. 244—(Closed.) Suit filed March, 1942. Settled and dismissed December 14, 1945. Expense, $100.00, paid February 28, 1946.

Case No. 246—(Closed.) Suit filed October, 1942. Dismissed.

Case No. 249—Suit filed January 6, 1944. Pending.

Case No. 250—Suit filed December 7, 1944. Pending.

Case No. 251—Suit filed September 25, 1942. Pending.

Case No. 252—Suit filed August, 1944. Pending.

Since August 1, 1945, and up to August 1, 1946, the following seven new cases have come before the committee, one of which has been closed, making a total of fourteen cases pending at the present time as against fifteen unclosed cases at the same time last year:

Case No. 253—(Closed.) Suit filed July, 1945. Four days' trial; verdict for the defendant. Expense, $1,050.00, paid June 5, 1946.

Case No. 254—Suit filed August 1, 1945. Pending.

Case No. 255—Suit filed September, 1945. Pending.

Case No. 256—Suit filed February 27, 1946. Pending.

Case No. 257—Suit filed December 5, 1945. Pending.

Case No. 258—Suit filed December, 1944. Pending.

Case No. 259—Suit filed December, 1945. Pending.

2. *Medical Defense Fund.* Statement, from August 1, 1945, to August 1, 1946:

Balance, August 1, 1945		$4,057.73
Receipts:		
Dues, 1—1944 member	$ .75	
121—1945 members	90.75	
3,229—1946 members	2,421.75	2,513.25
Interest on bonds		312.50
		$6,883.48
Disbursements:		
Malpractice fees	$1,150.00	
Salary of Association attorney	1,800.00	
Treasurer's bond	37.50	2,987.50
Balance in Medical Defense Fund checking account, August 1, 1946		**$3,895.98**

3. *Group malpractice insurance.* We have continued a close cooperation with the St. Paul Mercury Indemnity Company which entered into an agreement with the Executive Committee two years ago for a group contract for malpractice insurance. That agreement followed the unanimous approval of the 1943 House of Delegates of such a plan. To date the plan has proved satisfactory, although some conferences with the company's state agency have been necessary to straighten out some questions and misunderstandings of members concerning the policy. Company officials have consulted our attorney and committee in cases of problems arising out of threatened liability suits, being guided by the advice received.

To date a considerable group of physicians carry their professional liability in the St. Paul Mercury Indemnity Company, but the percentage of enrollment is not as large as this committee had hoped. If such a plan is to be successful, it should be supported by the great majority of the members of our society. Such has been the experience in other societies where similar plans of cooperation are in effect. Then the association is in a better position to study the loss ratio and request a reduction in the premium rate. The company requests a two-year period as a basis of determining its loss experience and a study of that loss ratio is being made. We feel that physicians are willing to pay the cost of adequate malpractice coverage if they know the rate charged is justified by experience. We urge your support of this program.

IN CONCLUSION

As we write "finis" to another successful year we may be prone to settle back self-satisfied and rest on our laurels, as the saying goes. But the profession dares not relax its vigilance. The public must be protected against the unscrupulous cultist who would prey upon the sick and weak for their gold; the socialistic program of the starry-eyed dreamers who envision government-controlled medicine must be replaced with sound thinking and common sense, and medicine must continue its high standards and increase its prestige with our people.

Next January a new session of Congress will begin and the Indiana General Assembly will commence its 61-day biennial meeting. We call upon every member of the association to take an interest in legislation that would be harmful to the best health interests of the public. It is the responsibility of every doctor to contact his representatives in Congress and the state legislature in opposition to dangerous legislation.

The Executive Committee has received full support and cooperation from the officers and membership of the association. It has been a pleasure to serve under these pleasant conditions, and we are most grateful and appreciative of the consideration always accorded us.

CLEON A. NAFE, M.D., *Chairman*,
C. H. MCCASKEY, M.D.,
J. E. FERRELL, M.D.,
F. T. ROMBERGER, M.D.,
A. M. MITCHELL, M.D.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Our activities during the past year have been primarily in the field of national legislation inasmuch as there was no session of the Indiana General Assembly. However, in voicing Indiana Medicine's views on federal legislation your committee did not overlook the fact that the Assembly will begin its sixty-one-day session next January.

Seven bulletins were sent to chairmen of county legislative committees and county medical society officers. Two bulletins were mailed to presidents and secretaries of Woman's Auxiliary units. All had to do with legislative matters, and in some instances the bulletins asked that senators and representatives be contacted. The quick and wholehearted response to these requests were most gratifying.

Annual Registration Law

In conformity with the action of the House of Delegates at French Lick last November, a bill has been prepared for introduction in the coming General Assembly which would establish an annual registration of two dollars for all practitioners licensed by the Board of Medical Registration and Examination.

Wagner-Murray-Dingell Bill Defeated

In opposing passage of the Wagner-Murray-Dingell Bill in the 79th Congress, your Committee on Public Policy and Legislation lost no opportunity to register opposition to this measure. Hoosier senators and representatives were kept informed of physicians' opposition to this and other bills which would be harmful to private practice. It may be said that Indiana did its full part in defeating the Wagner-Murray-Dingell Bill, but we dare not believe that the battle has been won. The long-haired reformers in Washington are not whipped and will likely launch a new and more vicious attack against the profession in the 80th Congress.

The 1947 General Assembly

Election day is November 5. Every doctor should be informed as to the views of candidates for the General Assembly from his respective county. We regret that efforts of your committee to get doctors nominated for the Senate and House of Representatives was to no avail. Only one physician consented to seek nomination, but he was defeated in the primary election. The profession will be handicapped in the next General Assembly by not having a doctor member.

In conclusion, your committee wishes to emphasize that the responsibility of getting good health laws enacted and defeating bad ones rests with all members of the association, and not alone with this committee. All doctors should assume a share of this legislative job. Each can exert some influence in the proper direction—and at the proper place. The success of your committee depends largely on the cooperation it receives from the profession at large.

We acknowledge the willing services that the county legislative committees, county society officers, and officials of the Woman's Auxiliary Chapters have performed at the behest of your committee. Orchids go to them for working hand in hand with this committee, and for the results attained.

NORMAN M. BEATTY, M.D., } *Co-chairmen,*
J. WILLIAM WRIGHT, M.D., }
JOHN HEWITT, M.D.,
HAROLD J. HALLECK, M.D.,
ROBERT L. GLASS, M.D.,
JOHN PALM, M.D.,
GEORGE DANIELS, M.D.,
J. R. DOTY, M.D.,
O. T. SCAMAHORN, M.D.

BUREAU OF PUBLICITY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Through the media of newspaper, radio, and the spoken word your Bureau of Publicity has endeavored diligently to serve as the mouthpiece of Indiana Medicine throughout the past year. The responsibilities entrusted to the bureau have been so voluminous that sixteen meetings were required to transact its business. The members weighed all matters carefully, and decisions were made in the light of what was best for the medical profession. Every effort was expended toward establishing a better understanding and friendly relations between the lay public and the profession; in other words, good public relations.

Work of the bureau may be illustrated best by taking up each activity separately.

Newspaper Releases

The establishment of a health column exclusively for weekly newspapers has highlighted activity in this field. The column, entitled "Hints on Health," was offered to editors who cared for it either in mat or mimeograph form, and seventy-four requested it. Additional requests raised the number to ninety-one. Columns have been sent out weekly since August 27, 1945.

"Hints on Health" has a two-fold purpose. First, to provide weekly papers with a timely health feature without cost to them, thus developing a friendly attitude toward the Indiana State Medical Association. Second, to disseminate helpful health information to the public and to encourage people to go see a doctor instead of trying self-medication.

During the year columns were written on the following subjects:

Watch Out for Poison Ivy.
Avoiding Typhoid Fever.
An Insect in the Ear.
The School Room Diseases.
The House We Live In.
Five Dollars for a Boil.
Let the Sunlight In.
Eat Milk, Fruits, and Vegetables.
Early Signs of Tuberculosis.
Wrong Use of Laxatives.
Find What Causes Headaches.
The Treatment for Pimples.
Tularemia, or Rabbit Fever.
A Nervous Breakdown.
A Convulsion: What To Do.
Got a Cold? Stay at Home!
Aspirin for Headache.
Beware of Home Treatment.
Broken Arches.
Thoughts About Cancer.
Fear Cancer? Be Examined!
Heed the Danger Signals of Cancer.

Take No Chances With Diphtheria.
Soap, the Germ Killer!
Working With a Temperature.
"Flu" Requires Doctor's Care.
Facts About Sinus Infections.
The Common Cause of Constipation.
That Tired Feeling.
Causes of Nervousness.
Whooping Cough.
Milk is a Valuable Food.
If Well, Keep Well!
Worry Causes Insomnia.
Impaired Hearing in Children.
Rheumatic Fever.
Prevention of Lockjaw.
Athlete's Foot.
Dangers from Underweight.
Swat the Fly!
Moving Injured Persons.
Arch Supports.
Danger of Tennis.
Ice in Cold Drinks.
The Pesky Chigger.
Patent Medicines.

Physicians are invited to prepare an article or articles for use in future "Hints on Health" columns. Articles must not exceed three hundred fifty words, and must be written so that lay readers can understand them. Contributions should be sent to the Bureau of Publicity, 1021 Hume Mansur Building, Indianapolis 4, Indiana.

The policy of frequent news releases on timely health topics to all papers, including dailies and weeklies, has been continued. Many of these articles have been prominently displayed.

Titles of these releases follow:
Sunstroke and Heat Exhaustion.
Back to School.
Annual Session of the Indiana State Medical Association, French Lick (9 releases).
How to Care for a Cold.
Care of the Skin.
Give Yourself a Present.
Holiday Health Suggestions.
Better Medical Care in 1946.
Secretaries' Conference.
Health and the Housing Shortage.
Never Mind the Weather.
Better Eat Breakfast.
Pay Attention to Your Appendix.
Nutrition and the New Bread.
Health Examination for Birthday Present.
Healthy Hearts.
Kidney Care.
Diet and Old Age.
Arteries and Old Age.
Child Health Day.
Fitness at Fifty.
Watch Children's Ears.
Gardening.
Time for Sunburn.
Watch Out! It's Summer!
Diabetes.
Beware of Too Much Sun!
Ivy Poisoning.
Snake Bite is Vacation Danger.
Eat Foods That Help Keep You Cool.

In addition to articles on medical subjects, the bureau has distributed news about the annual session, Secretaries' Conference, Indiana sightseeing trip to A.M.A. meeting at San Francisco, and its radio programs.

Radio Broadcasts

During the year the fifteen-minute broadcasts over radio station WFBM, Indianapolis, were continued, but the name of the program was changed from "Doctor Goodhealth" to "Ladies, Your Health." Inasmuch as the broadcasts were given in the afternoon when women are the principal listeners, the script was changed to cover health subjects of particular interest to women. Beginning last June a series of A.M.A. electrical transcriptions entitled "Time Out" replaced the locally-written program, and a new series entitled "Melody of Life," also supplied by the Bureau of Health Education of the American Medical Association, was scheduled to follow "Time Out."

Outside of Marion County twenty-three county medical societies have radio stations within their confines. A bulletin was sent to these societies urging them to ask their local radio station to use the A.M.A. recordings.

A series of five five-minute scripts on voluntary health insurance was prepared and sent to societies for use on their local radio stations.

The bureau is still working on plans for a commercially-sponsored program at some good night hour, but nothing definite has been worked out at this writing.

Titles of the "Ladies, Your Health" broadcasts follow:

Health and Beauty.
Over- or Under-weight.
Skin Care.
Virus Diseases.
Arthritis.
Rh. Factor.
Colds.
Diabetes.
Tuberculosis.
Health on Christmas List
Allergy.
Review.
Eyes.
Polio.
Alcoholics.
Birthday Wishes.
Heart.
Appendicitis.
Voices and Health.
Cancer.
Health for Spring Beauty.

Hypertension.
Mental Spring Housecleaning.
Public Health Nursing—with local PHN representatives.
Geriatrics.
Teeth.
Child Health—with Dr. Robert Jewett.
Summer Health Hazards.
Sunning.
A Man's Slant on Women's Health.
Health Insurance.

Speakers Provided

During the year the bureau supplied speakers for fourteen meetings, including radio broadcasts, civic clubs, medical and women's clubs. A definite need exists for more doctor speakers, particularly on the federal health bills.

Speaking engagements filled during the year before lay and medical groups follow:

1945

August 31—Optimists Club, Indianapolis.
September 7—Howard County Medical Society, Kokomo.
October 17—Lions Club, Mentone.
October 25—Dearborn-Ohio County Medical Society, Aurora.
November 16—Cass County Medical Society, Logansport.
November 19—Randolph County Medical Society, Winchester.
December 5—Wabash County Medical Society, Wabash.

1946

January 9—Parent-Teacher Association, School 69, Indianapolis.
January 16—Parent-Teacher Association, School 39, Indianapolis.
January 18—Cass County Medical Society, Logansport.
February 11—Rotary Club, Connersville.
March 26—Lions Club, Pendleton.
March 26—Allen County Medical Auxiliary, Fort Wayne.
April 11—Green County Medical Society, Linton.

The bureau recommends, when speakers are asked to travel long distances to address meetings, that special effort be made to get out a sizeable audience to hear them. On several occasions speakers have spent much time, traveling many miles, to address only a few persons.

Files of current material on federal legislation and medical economic subjects are kept by the bureau in state headquarters to help speakers who desire assistance.

Auxiliary Programs

Upon request of the Program Committee of the Woman's Auxiliary, ten typical programs for local auxiliaries were prepared by the bureau. Copies of these suggested programs were mimeographed for the committee. As advisory committee to the state auxiliary, the bureau is ready and willing to help wherever it can. The Auxiliary is doing a good job for Indiana Medicine through its multiplicity of activities. Its growth should be encouraged, for it can wield a powerful influence in behalf of our profession.

Bureau Financial Statement

The expenditures of the Bureau of Publicity from August 1, 1945, to August 1, 1946, follow:

Clippings	$ 84.95
Postage	215.01
Stationery and mimeograph supplies	183.04
Printing	483.71
Salary, script writer	1,245.98
Broadcasting expense	375.00
Miscellaneous	52.93
	$2,640.62

HOMER G. HAMER, M.D., *Chairman.*
BEN B. MOORE, M.D.,
KARL R. RUDDELL, M.D.

COMMITTEE ON CIVIC AND INDUSTRIAL RELATIONS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Civic and Industrial Relations held no meeting during the year and therefore has no report to make at this time.

G. H. WISENER, M.D., *Chairman,*
FRED B. WISHARD, M.D.,
PHILIP E. YUNKER, M.D.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Medical Education and Hospitals had no meeting this year; therefore it has no report to make.

ROBERT M. MOORE, M.D., *Chairman,*
E. N. KIME, M.D.,
C. J. CLARK, M.D.,
O. O. ALEXANDER, M.D.,
HERMAN M. BAKER, M.D.,
HARRY P. ROSS, M.D.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

A meeting of the Indiana State Medical Association Council on Medical Service and Public Relations was held on June 2, 1946, for the purpose of

outlining a program of activity. It was pointed out that the function of this Council is to cooperate with the parent Council of the American Medical Association in furthering their objectives on a state level, and on this basis to support the suggestions and plans of this body through progressive measures and active participation.

The following twelve-point program was adopted:

1. There should be meetings of all county society presidents and secretaries three times a year for the purpose of bringing the county societies, through their officers, into closer contact and participation with the state organization and its affairs, and to afford the means for free and open discussion of problems in order that a firm bond of cooperation and enterprise may be established. A special meeting of such officers should be called to promote the enthusiastic acceptance of Mutual Medical Insurance, Inc. Through such meetings a definite attempt should be initiated to induce medical men and their wives to take a representative part in all civic organizations.

2. To enlist the aid of hospitals and druggists and individual physicians in distributing pamphlets dealing with health subjects, and particularly with voluntary as opposed to compulsory health insurance. This should be an active personal distribution and not conducted on a "take one" basis. The cooperation of the Indiana Inter-Professional Health Council is to be sought in carrying out this program.

3. Plan to support and implement the ten-point program of the American Medical Association.

(a) By devoting a page in THE JOURNAL each month to an explanation of the points, and suggesting means of cooperation with the points.

(b) By securing the assistance of the Bureau of Publicity in explanation of these points to the press.

(c) By securing radio recordings for use throughout the state by the various broadcasting stations on all health topics, and particularly those in support of the ten-point program.

(d) These points, in brief, deal with:

1. High Standard of Living.
2. Preventive Medical Services.
3. Adequate Maternity Care.
4. Adequate Infant and Child Care.
5. Health and Diagnostic Centers and Hospitals.
6. Extension of Voluntary Prepaid Medical and Hospital Care Plans.
7. Adequate Medical and Hospital Care for the Veteran.
8. Research in the Medical Sciences.
9. Proper Development of National Philanthropic Health Agencies.
10. Widespread Health Education.

4. The suggestion to the various county societies that they hold luncheon or dinner meetings with individual groups of representatives and leaders of labor, industry, farmers, teachers, churchmen, politicians, veterans, women's organizations, civic groups, and other leading organizations, to be followed by a debate on voluntary vs. compulsory health insurance by well-informed authorities. It is suggested that such groups be invited singly or in small groupings that have a common interest, rather than attempting to have large gatherings of all groups at any one time.

5. The securing of a brochure dealing with compulsory health insurance, indicating arguments for and against, for distribution to all high schools and colleges throughout the state for their use in debates and for reference. It is understood that the American Medical Association has such a brochure in preparation.

6. Following distribution of such a brochure, the offering of a prize of $100, $50, and $25 for the best, second, and third best essays on the subject of compulsory health insurance, written by college students, and similar prizes for high school students—the object being to develop an interest in and a knowledge of what compulsory as opposed to voluntary health insurance means, and the dissemination of this interest and knowledge to parents and friends.

7. Institute a three-day course in public speaking for the doctors who will volunteer from each county. It is felt that there should be at least one volunteer for each ten members. During this course, to be conducted by experts, the volunteers will be indoctrinated in factual data regarding compulsory health insurance and given practical demonstrations as well as individual experiences in presenting the topic. It is also suggested that a similar course might well be initiated by the Woman's Auxiliary.

8. "Know Your Hospital." "Meet Your Doctors." Take advantage of National Hospital Day, and have the entire staff present at the hospitals to conduct, personally, various groups through the hospital and explain its workings. This might require two or three hours' stay in the hospital, but should pay dividends in the response of the people to this interest.

9. Propose one, two, or three pointed questions each month in THE JOURNAL, with answers on another page, dealing with compulsory health insurance, under the heading "How Would You Answer This?"

10. Publication each month in THE JOURNAL of a contrasting color four-page department devoted to pointed and briefed statements concerning what goes on in medicine from an economic, legislative, and public relations standpoint. This is to be supplemented by the improvement of relations among our own membership by having a number of men, representing the state organization, meet with the county societies at regular meetings, and carry to them the latest developments in the practical side of medicine from a state and national viewpoint.

11. An active and interested development of

contacts with our representatives in congress, and the cultivation of a friendly exchange of viewpoints to the end that the aspects of medicine may be continually before them. Not a hurried, last-minute letter or telegram on a controversial issue, but a year-round acquaintanceship and a frequent and continuous representation to them of the things for which medical practice stands.

12. Efforts directed toward securing the cooperation of the American Medical Association in subsidizing the making of a three- to five-reel film carrying the underlying theme of compulsory vs. voluntary health insurance worked up in an interest-compelling story form; copies of this film to be loaned to the states and shown throughout the various cities and counties at free open meetings for the public.

Your Council on Medical Service and Public Relations recommends the institution of this program and the adoption of this report.

N. K. Forster, M.D., *Chairman,*
C. A. Nafe, M.D.
C. H. McCaskey, M.D.
J. E. Ferrell, M.D.
F. T. Romberger, M.D.
A. M. Mitchell, M.D.
N. M. Beatty, M.D.
J. W. Wright, M.D.
B. B. Moore, M.D.
W. U. Kennedy, M.D.
G. H. Wisener, M.D.
W. H. Howard, M.D.
E. M. Shanklin, M.D.
Ray E. Smith.
R. S. Weesner.

THE JOURNAL

House of Delegates,
Indiana State Medical Association.

Gentlemen:

For the year 1946, we confidently believe that The Journal has made a most excellent showing. While the number of pages printed is no fair criterion of accomplishments, yet we all have an interest in those figures. Advertising in such a magazine as ours is its very lifeblood; hence, some recital of our increase in advertising may be in order.

During the year 1940 we used 506 pages for our advertising; year by year this has been increased until in 1945 we printed 754 advertising pages, producing a decidedly healthy increase in income. Reading pages have shown a like increase, the average number of pages per issue for 1945 amounting to 111.1.

As was to be expected, our printing costs were definitely higher than in former years, there having been a step-up in these costs for the current year. Paper stock, of course, costs more than in former years, but we feel that The Journal has been most fortunate in having been able to get the same high quality paper as in the past, and which goes for the making of a "good looking" magazine. Several other state journals have inquired as to just how we manage to get such paper stock, and a few have asked how we are able to get such a first-rate printing job.

Speaking of the printer, while there have been many delays—seldom has The Journal appeared on the desks of our members on scheduled time, yet on the whole we have had splendid cooperation and have been given an enviable product.

The staff has been increased by the naming of an Associate Editor, Dr. N. K. Forster, who will, among other things, conduct a monthly discussion of "What is going on, medically, outside the State of Indiana." Doctor Forster has access to all medical journals, plus the bulletins issued by many county medical groups over the country, and it is from the latter that he will glean most of his columns.

Ray Smith, our new Executive Secretary and Managing Editor, will devote much of his time to Journal affairs, and also will conduct a monthly Secretary's column, a la Maurice Early, of the *Indianapolis Star.* Maurice, as most of you know, in his "The Day in Indiana," discusses live, up-to-the-minute topics of current interest; Ray will do the same thing as to what is going on in Indiana Medicine, gleaning his material from personal contacts over the state and from his correspondence with the "grass roots of medicine," the county medical societies. We believe that these two new columns will be of much interest to our members, as they will bring up-to-date information as to what is going on in the field of medicine.

While The Journal has not been too militant in the past year or two, when so many weighty problems were before us, neither has it taken a "middle-of-the-road" attitude. We have expressed opinions on many of these problems, yet we have made no definite attack on the "hierarchy at 535 North Dearborn Street, Chicago." A few of our state association official magazines have been outspoken at times, occasionally dipping a bit into the vitriol instead of common ink. While we have no quarrel to make with these editors, we have not felt that wide publication of such matters is the proper answer. Of recent years we have in no sense subscribed to the belief that the "Brass Hats" have made no errors; on occasion, via personal letters, we have commented on such affairs, occasionally making a personal call at A.M.A. headquarters.

With the removal of The Journal headquarters' staff into more comfortable and commodious office space, we have been able to render much more service than in former years. However, we need a bit more equipment, one important item being a Kardex filing system of our own. It is true that there is one in the general headquarters, but our files are used almost constantly for reference and checking purposes and there are many objections to our having to run over into the other office for

such information, plus the fact that the information we need in our files often is not found in the other file. The Editorial Board at a recent meeting voted unanimously in recommending that the cost of such a filing system be included in the 1947 budget.

For the office staff we have naught but the highest praise. They are all efficient; willing to work overtime if necessary, and, considering the many handicaps that have beset us in recent years, they have done and are doing a "bang-up" job. Mechanically speaking, ours is a most attractive magazine, the chief reason being that our Miss Rokke personally supervises the make-up. If, for example, we are to have some special number, she will search for weeks, seeking *exactly* the *proper* picture to use for that cover page, all of which explains the rather frequent letters we receive concerning our attractive JOURNAL.

We believe that our scientific section has been of the highest order, although the problem of securing papers has at times been a tough one to solve. Medical men have been busy during the war years, and are even now busy; many of them want to "rest up" a bit—take a needed vacation, hence, do not want to be committed to writing papers just now. However, while our backlog continues to be very low, we have managed to come to you each month with papers of superior merit.

It has been a pleasure to have served you for the past fourteen years; at the same time most profitable, since this work has required a great deal of reading, probably more than we would have done "on our own." In conclusion, we frankly believe that your JOURNAL is "tops"; it is clean, attractive, informative, and widely read.

We wish to thank all those who have contributed to it, for it is only through a coordinated effort that such a magazine as ours is made possible.

E. M. SHANKLIN, M.D., *Editor.*

COMMITTEE ON SECRETARIES' CONFERENCE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The meeting of the Secretaries' Conference was held in Indianapolis on January 13, 1946, at the Columbia Club, with A. M. Mitchell, M.D., of Terre Haute, presiding. There was a good attendance. The speakers were Floyd Romberger, M.D., of Lafayette; F. S. Crockett, M.D., of Lafayette; Jack Meadors, of South Carolina Medical Association; O. E. Wilson, M.D., of Elkhart; W. U. Kennedy, M.D., of New Castle; E. J. McCormick, M.D., of Toledo, Ohio; and C. F. Thompson, M.D., of Indianapolis.

A dinner was served which was well attended. The after-dinner speakers were J. E. Ferrell, M.D., President of the Indiana State Medical Association, and Major General Paul R. Hawley, Acting Surgeon General, Veterans Administration, Washington, D.C.

A. M. MITCHELL, M.D., *Chairman.*
O. E. WILSON, M.D.
I. E. HUCKLEBERRY, M.D.
ABRAHAM M. OWEN, M.D.
W. A. KURTZ, M.D.

COMMITTEE ON NECROLOGY AND HISTORY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The report on necrology is published annually in the earliest possible number of THE JOURNAL.

Much of the material collected for a Medical History will be submitted to the writer for the Centennial Memorial Volume, to be published by the Centennial Celebration Committee.

JAMES B. MAPLE M.D., *Chairman.*
W. D. INLOW, M.D.
L. G. ZERFAS, M.D.
E. R. CLARKE, M.D.
ROBERT H. PIERSON, M.D.
HARRY H. SANDOZ, M.D.
CHARLES F. LEICH, M.D.

COMMITTEE ON PHYSICAL FITNESS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Physical Fitness had no meeting during the year, and therefore has no report to make.

W. A. THOMPSON, M.D., *Chairman.*
ABRAHAM M. OWEN, M.D.
ROBERT H. WILLIAMS, M.D.
G. A. THOMAS, M.D.
JOSEPH B. QUIGLEY, M.D.
JOHN W. WONER, M.D.
H. W. EIKENBERRY, M.D.
JAMES M. KIRTLEY, M.D.
O. H. BAKEMEIER, M.D.

COMMITTEE ON MENTAL HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Mental Health met on August 3, 1946, in the office of the Indiana State Medical Association. The following members were present: Murray DeArmond, chairman; C. L. Williams, L. P. Harshman, and G. E. Metcalfe.

The committee recognized the work of the late Dr. LaRue D. Carter by the following resolution:

WHEREAS, the hand of destiny has seen fit to remove from us our illustrious chairman, Dr. LaRue D. Carter; and

WHEREAS, the work of the Committee on Mental Health of the Indiana State Medical Association has been due in large part to the profound forethought, careful planning, and wise counsel of Dr. LaRue D. Carter; and

WHEREAS, Dr. LaRue D. Carter, by his diligence in teaching and careful attention to detail in his consultation work, had gained prestige to where he was recognized among his colleagues as the Dean of Neuropsychiatry in the State of Indiana; and

WHEREAS, the existence of the Indiana Council for Mental Health has been due in large part to the prolonged study and consideration of Dr. LaRue D. Carter; and

WHEREAS, this Committee has deeply missed his counsel and guidance in the last few months and feels moved to honor his memory: Therefore be it

RESOLVED, That the Committee on Mental Health of the Indiana State Medical Association take this opportunity to express its feeling of profound loss in the untimely passing of its chairman, Dr. LaRue D. Carter.

The committee received an informal report by Dr. C. L. Williams, Director of the Indiana Council for Mental Health, and commended the council in the progress of its efforts to raise the standard of care and treatment of mental patients.

Dr. Palmer R. Gallup, Director of the Division of Mental Hygiene of the State Department of Public Welfare, appeared before the Committee and presented the problem of meeting the psychiatric needs in the mental hygiene clinics now in operation by the State Department of Public Welfare. After considerable discussion the committee favored legislative action to enable the clinics to charge a fee for the psychiatric service when a patient is able to pay, the fee scheduled to be on a sliding scale with a maximum charge below the level established in private practice.

The recent wave of publicity of a national character has been repeatedly brought to the attention of the committee. The committee is not unmindful of the effects of this publicity. It is well aware of the incendiary type of mass psychology to do something about it. The committee is further aware of the various types of misplaced implications that these articles have given, and in their many contacts have tried to correct the distortion of ideas and to bring to people more realistically, and in their proper perspective, more true facts regarding their publicity. The committee is well aware that the national publicity, along with other publicity and discussion by various organizations and groups of this publicity, points to rumblings of the people to realize that conditions are not as they should be in all of our state mental hospitals. The committee is in hopes that since this publicity has started, that the legislators will not be unmindful of it and will help to provide adequate funds so that many conditions can be corrected.

The committee considered the problem of hospital service for the diagnosis, treatment, and care of psychiatric and nervous conditions. It was unanimously agreed that the opening of the new psychiatric hospital at the Indiana University Medical Center would not meet all the needs for this type of care. It was further agreed that this hospital would show what could be done in the way of psychiatric care, and by its teaching program would increase the need for this type of care throughout the state. The committee strongly recommends that general hospitals consider this problem, for they will meet it frequently. Bennett has shown:

1. That 10 per cent of all general hospital beds are needed to treat psychiatric patients.
2. Further, that a community of 100,000 can support a twenty-five bed psychiatric department in its general hospital.
3. The psychiatric department does not need a separate plant.
4. Only slight remodeling is needed to adapt ordinary hospital facilities to the needs of the psychiatric department.
5. As a rule, the psychiatric department can be made a self-sustaining unit, economically.

Since the civil population is becoming increasingly psychiatrically-minded, and there will be many more trained psychiatrists, nurses, and social workers in the field, consequently, in the not too distant future there will be psychiatrically-trained help to care for patients in general hospitals.

Up to 1940 there were 4,302 general hospitals in the United States, 90 per cent of which did not permit the admission of a known psychiatric patient. Up to 1940 only 89 general hospitals had provided any facilities for psychiatric care.

The committee further recommends that general hospitals take the necessary steps in their future planning to provide wards of adequate size in which the treatment of psychiatric and nervous conditions could be provided. When general hospitals recognize this problem and take steps to meet it, they can live up to their name of really being general hospitals.

MURRAY DEARMOND, M.D., *Chairman*,
L. P. HARSHMAN, M.D.,
C. L. WILLIAMS, M.D.,
E. ROGERS SMITH, MD.,
G. E. METCALFE, M.D.,
MAX BAHR, M.D.

REPORT OF THE COMMITTEE FOR THE STUDY OF LAY ACTIVITY OF MEDICAL PRACTICE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The committee met on Sunday, August 18, 1946. Present: W. D. Gatch, M.D., chairman; A. E. Stinson, M.D., K. I. Sheek, M.D., and O. O. Alexander, M.D.

The committee discussed the present state of medical practice and the present relations between the medical profession and the public. The members agreed that over-specialization is a great evil which is injurious to both the profession and the public; that it is a chief cause of the present trend toward socialized medicine. They also agreed that the Indiana State Medical Association should support with all its power any plans to improve the status of the general practitioner. One member made the point that federal control of medical practice in Indiana, by prescribing how federal appropriations for public health, maternal and child welfare, care of the aged, etc., shall be expended, is illegal; this, because the regulation of the practice of medicine in the state is vested in the state legislature. A legal opinion on this matter is desirable.

The committee decided to submit the following recommendations:

1. That the Indiana State Medical Association support the plan to give medical care to veterans in their home communities by physicians of their own choice.

2. That the President of the Indiana State Medical Association appoint a committee to confer with nursing educators and hospital administrators on how to increase the number of nurses, and how to improve nursing care. The American Surgical Association at its last meeting appointed a committee to investigate the present state of nursing education. This committee states that "as more and more attention has been given to elevate the standards of nursing education, less and less emphasis has been placed on the care of the sick." Warthem and Williams, in an editorial in the July issue of *The Virginia Medical Monthly* propose the following program for Virginia: "There are many physicians and some graduate nurses who believe that the present policies and practices of the schools, associations, and boards for nursing have brought the profession to a critical crossroad. To continue on the course now being followed will lead to the disappearance of the graduate nurse as we have known her in the past. It is not too late to make a radical revision of the curriculum and restore the training of the graduate nurse to a sane basis."

3. That the association prepare a law which will give the staffs of county hospitals greater authority in their administration. Several glaring instances of the evils of lay control of these hospitals have occurred within the last year.

4. That no county society grant its support to any organization seeking to raise money for a health project unless the promoters thereof submit their propaganda to the society for its approval, and unless they agree to have a public accounting of their collections and expenditures.

W. D. Gatch, M.D., *Chairman,*
O. O. Alexander, M.D.,
O. W. Sicks, M.D.,
A. E. Stinson, M.D.,
Kenneth I. Sheek, M.D.,
George K. Balsbaugh, M.D.,
M. C. Pitkin, M.D.,
Robert Smallwood, M.D.,
Arnold H. Duemling, M.D.

ADVISORY COMMITTEE TO THE DIVISION OF MATERNAL AND CHILD HEALTH OF THE INDIANA STATE BOARD OF HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Advisory Committee to the Division of Maternal and Child Health held no formal meeting during the current year for two reasons: first, the program has not been altered in its scope; and secondly, there has been some difficulty in regard to the appointment of the committee.

The United States Children's Bureau asked that the Advisory Committee be appointed by the Indiana State Board of Health. It was necessary to wait for a decision of the State Board of Health on this matter. It was finally decided in June that the State Board of Health would select six members of the committee appointed by the Indiana State Medical Association. These members are as follows:

G. W. Gustafson, M.D., Obstetrician—Indianapolis.

Rex W. Dixon, M.D., General Practice—Anderson.

R. R. Hippensteel, M.D., Pediatrician—Indianapolis.

J. C. Carter, M.D., Pediatrician—Indianapolis.

Harold Eggers, M.D., Obstetrician—Hammond.

J. C. Glackman, Jr., M.D., General Practice—Rockport.

Since there was no change in the Maternal and Child Health Program, it was decided by the chairman, Dr. G. W. Gustafson, that a meeting would not be held until the meeting of the Indiana State Medical Association in the fall. An announcement of the meeting place and time will be sent to the committee at a later date.

Following is a report of the activities of the Division of Maternal and Child Health of the Indiana State Board of Health for the fiscal year ending June 30, 1946:

DIVISION OF MATERNAL AND CHILD HEALTH

ROBERT E. JEWETT, M.D., *Director.*

The functions of the Division of Maternal and Child Health are the promotion of better health facilities, and better medical and nursing care for mothers and children. This is accomplished by means of educational programs for professional persons and the public, and direct public health service programs, all aimed at the prevention of sickness and death. In carrying out its functions the division cooperates with, or works through, other Divisions of the Indiana State Board of Health, particularly the Division of Public Health Nursing, and it provides direct financial aid in the establishment and maintenance of local public health services.

Education involves the purchase and distribution of literature, public talks, radio programs, in-service training, and consultation and guidance in maternity and child care for physicians and other professional persons. Direct services are provided through finanical assistance and consultant services for public health nursing programs, and local medical and nursing services for mothers and children.

The field of maternal and child health includes the improvement of standards of medical, nursing, and hospital care during the maternity cycle, and during the pre-school and school years of the child. The division has helped to promote and maintain child health conferences, prenatal clinics, and immunization programs under the direction of local physicians, and it was responsible for the supervision and licensure of hospitals until June 1, 1946.

A major responsibility has been the administration of the program for wives and children of men serving in the armed forces. This involves maternity care of wives and care of infants and children of men in the fourth, fifth, sixth, and seventh pay grades. A tabular report gives a statistical outline of the extent and magnitude of the services mentioned.

The case load for the Emergency Maternity and Infant Care Program has decreased about 20 per cent. Certain types of care not included under this program were provided with funds normally used for other maternal and child health services. The additional services have included maternity care for unmarried mothers and medical and hospital care of children over one year of age, who are not provided for under the EMIC program.

Child health conferences were supported or maintained in twenty-two towns. The prenatal clinics in Pike and Brown counties were active, and better care of the premature infant was promoted by the loan of approximately one hundred fifty premature-care incubators during the year.

The Brown County Maternity Nursing Service continues to provide for prenatal and postpartum clinics, nurse midwife care in the home for uncomplicated cases, and medical care in the home or hospital for complicated cases. The program provides for the employment of a qualified nurse midwife, fees for the physician, ambulance service and hospital care.

An Act of the 84th Indiana General Assembly gave the Indiana State Board of Health the authority for the licensing and regulating of hospitals. Until June 1, 1946, this was a function of the Division of Maternal and Child Health. During the year the division worked with the Council for Hospital Licensure in the drafting and proposing of regulations. These regulations were completed and promulgated by the Governor on May 3, 1946. A Division of Hospital and Institutional Service was established by the State Board of Health, and on June 1, 1946, the responsibility for supervising hospitals was transferred to this division. The Division of Maternal and Child Health continues to work closely with the new division, particularly in matters having to do with maternity care, nursery services, and the care of premature infants.

During the year the Nutrition Consultant Service was officially transferred from the Division of Maternal and Child Health to the Division of Health and Physical Education.

In the fall of 1945 a Medical Social Service Program was inaugurated. Under this program the Medical Social Work Consultant provides direct case consultation service, provides consultant service to other divisions of the State Board of Health and to branch office and local health agencies. The consultant also serves as the liaison representative to official and private social service agencies.

During the year efforts were made to extend the Public Health Services for children. A qualified pediatrician, Dr. Walter Stoeffler, was placed on the staff and made responsible for the child health aspects of the Maternal and Child Health program. This specialist was appointed Executive Secretary of the State Committee of the American Academy of Pediatrics, and he inaugurated a child care study sponsored by the academy in cooperation with the National Foundation for Infantile Paralysis and the Crippled Children's Society.

SUMMARY OF EMERGENCY MATERNAL AND INFANT CARE PROGRAM

Maternity cases authorized	8,454	
Amount paid to physicians for maternity care	$414,768.13	
Amount paid for hospital maternity care	464,851.00	
Other maternity costs (nursing, clinic, ambulance, drugs)	13,426.35	
TOTAL EXPENDITURES		$893,046.03
Average cost per completed maternity case		97.60
Pediatric cases authorized	1,843	
Amount paid to physicians for pediatric care	$20,682.21	
Amount paid for hospital pediatric care	47,553.11	
Other pediatric costs (nursing, clinic, ambulance, drugs)	2,456.65	

TOTAL EXPENDITURES	66,497.93
Average cost per completed pediatric case	44.01

G. W. Gustafson, M.D., *Chairman*,
Mahlon F. Miller, M.D.,
Foster J. Hudson, M.D.,
R. A. Craig, M.D.,
Rex W. Dixon, M.D.,
Milo K. Miller, M.D.,
R. R. Hippensteel, M.D.,
H. W. Eggers, M.D.,
Joseph H. Stamper, MD.,
Richard S. Bloomer, M.D.,
David L. Smith, M.D.,
James C. Carter, M.D.,
J. C. Glackman, Jr., M.D.

LIAISON COMMITTEE OF THE DIVISION OF SERVICES FOR CRIPPLED CHILDREN

House of Delegates,
Indiana State Medical Association.

Gentlemen:

This is to report that the Liaison Committee of the Division of Services for Crippled Children has had no business referred to it or transacted during the year, and therefore has nothing to report.

M. C. Topping, M.D., *Chairman*,
H. E. English, M.D.,
C. O. Almquist, M.D.,
George J. Garceau, M.D.,
George Cook, M.D.,
Robert B. Acker, M.D.,
Gordon W. Batman, M.D.

AUDITING COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Auditing Committee held its annual meeting at the Indiana National Bank, Indianapolis, on July 17, 1946.

At this time the investments of the association, as listed by Geo. S. Olive & Co., certified public accountants, in the treasurer's annual report (see page 521), were examined and found to be in order in both the General Fund and the Medical Defense Fund.

The 1945 interest rate on holdings in the General Fund, as computed by the accountants, was 3.158 per cent; while interest income on the Medical Defense Fund securities averaged 2.916 per cent.

Cash balances in The Indiana National Bank, The American National Bank, The Fletcher Trust Company, and The Bankers Trust Company, as shown by the bank statements, also were examined. These accounts consist of the General Headquarters Office Fund, the Medical Defense Fund, The Journal Fund, and the Petty Cash Fund, respectively.

O. B. Norman, M.D., *Chairman*,
Charles Wise, M.D.,
R. H. Elliott, M.D.

COMMITTEE ON CONTROL OF CANCER

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The work of the Committee on Control of Cancer has been devoted exclusively to the guidance and direction of projects for the Indiana Cancer Society. It will be noted that the Indiana Cancer Society is the outgrowth of the former organization known as the Field Army of the American Cancer Society. The Indiana Cancer Society is incorporated under the laws of the State of Indiana, and its officers for the year 1946 are: William H. Ball, Muncie, president; Mrs. Ronald M. Hazen, Indianapolis, executive vice-president; Clyde G. Culbertson, M.D., vice-president, Director of Research; Thurman B. Rice, M.D., vice-president, Director of Education; Chester A. Stayton, vice-president, Director of Services; Mrs. Carl G. F. Franzen, Bloomington, secretary; Harry B. Wade, Indianapolis, treasurer.

The society has forty directors, both lay and professional, representing all districts in the state. G. H. A. Clowes, Ph.D., is chairman of the Board of Directors.

Your committee held a meeting with representatives of the Indiana Cancer Society at the Riley Hospital on January 30, 1946. Those present: Drs. Willis D. Gatch, C. G. Culbertson, Don D. Bowers, John A. Campbell, Leroy E. Burney, William F. King, Frederic Taylor, Chester A. Stayton, Indianapolis; A. S. Giordano, and C. S. Culbertson, South Bend; W. D. Inlow, Shelbyville; Albert T. Jones, Pendleton; D. C. McClelland, Lafayette, and B. K. Zaring, Columbus. This committee unanimously adopted a resolution recommending:

1. A survey of cancer needs in Indiana by Dr. William F. King, Division on Geriatrics, of the Indiana State Board of Health.

2. The establishment of a tumor registry by:

   (a) The appointment of a board of pathologists to review slides with sections of tumors previously studied and reported by pathologists either in private practice or connected with hospitals.

   (b) The creation of a file of the slides.

   (c) The return to the original examining pathologist of a copy of the report of the board of review.

3. That the Indiana University School of Medicine present any desired instruction on cancer to

doctors in good standing in the state, and that these courses be set up as a local project for the Indiana Cancer Society on a state-wide basis.

4. That the matter of formation of cancer clinics be left to the discretion of the local medical societies. It was the opinion of this group that the committee should not use its influence to establish these facilities in any county.

5. That the committee approve the establishment of three-year fellowships in pathology and radiology, carrying a stipulated compensation of $2,000 per year with the understanding that the fellowship be served for three years in an institution with a recognized department of pathology or radiology.

6. As a committee we approve in principle as projects of county cancer societies the gift of laboratory or radiological equipment or radon seeds to the hospitals, providing the hospital has a professional and technical staff properly trained in the use of the equipment or radon seeds.

The American Cancer Society was reorganized this year in New York, and Mr. William H. Ball, president of the Indiana Cancer Society, was selected as one of its directors. The national quota in the campaign for funds was twelve million dollars. On July 31, 1946, $10,421,630.37 had been collected. The state quota in this drive was $282,000.00. On August 21, 1946, $253,611.81 had been collected. The division of this state fund is as follows:

Forty per cent to the American Cancer Society for the promotion of a greatly-enlarged program of national research, national education, surveys on a national level, and for the administration of the national office.

Twenty per cent to be retained in the state office for the promotion of projects on a state level, educational program, and the administration of the state office.

Forty per cent to be returned to the county units for local projects upon receipt in the state office of properly-approved project application blanks.

Research Funds

A large percentage of the funds sent to the American Cancer Society will be re-allocated to the various states for research. Any of the Indiana colleges or universities working on a research problem related to this disease and in need of funds to carry on this research should correspond with the American Cancer Society.

Education Workshop

A two-week workshop in cancer education was held at Indiana University, Bloomington, under the sponsorship of the Indiana Cancer Society and the supervision of Professor Carl G. F. Franzen, of the Department of Education of Indiana University. The purpose of this was to produce a book to be used in the secondary schools and to be distributed by the State Department of Public Instruction. Dr. Thurman B. Rice provided the medical and scientific data. The text should be ready for use in the 1946-47 school year.

Three hundred ninety thousand pieces of literature were distributed from the state office to the county units during the campaign.

The president of the Indiana State Medical Association appointed a special committee to study the cancer clinic situation and make a report to the meeting of the Council on April 14. This was in accordance with the directions of the House of Delegates at the annual meeting at French Lick. The report was submitted and the Council approved the majority report. (See page 326, June, 1946, JOURNAL.)

Conclusion

Cancer is a major public health program, second only to heart disease as a cause of death. Over 170,000 deaths a year are reported in the United States. *In women between the ages of 35 and 54 it ranks first as the cause of death.* Between the ages of 55 to 74 it ranks second; over 75, fourth. In men between the ages of 45 and 74, it ranks second; and between 35 to 44 and over 75, it ranks fourth. Twenty-five per cent of all deaths among women, between the ages 45 to 55, are due to cancer. The rate per 100,000 varies from 96 in rural areas to 146 in the large cities.

The reported death rate from cancer shows a steadily upward trend. This is believed to be due to improvement in diagnostic procedure and our increased longevity rather than an actual increase in the incidence of the disease. It is interesting to note that in 1900, 13,000,000, or 18 per cent, of the population was 45 years of age and over. In 1940, 35,000,000, or 27 per cent, were 45 years or over.

Over the past decade the trend of the death rate from cancer, all forms, has been steadily downward among women, according to the mortality experience of the Metropolitan Life Insurance Company.

C. A. STAYTON, M.D., *Chairman*,
E. E. PADGETT, M.D.,
WILLIAM A. SHUCK, M.D.,
E. M. VAN BUSKIRK, M.D.,
A. T. JONES, M.D.,
HENRY O. MERTZ, M.D.,
J. J. CONNELLY, M.D.,
A. S. GIORDANO, M.D.

* * *

MINORITY REPORT

I approve the above report with the addition of the following minority report:

If a cancer clinic is established, it is advisable that the patient be given a complete physical to include rectal and vaginal examination, CBC, urine examination and a flat x-ray of chest.

Patient should be billed for services rendered in accordance with ability to pay.

A. S. GIORDANO, M.D.

COMMITTEE ON VENEREAL DISEASE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Venereal Disease of the Indiana State Medical Association submits the following report:

1. The committee approves the recommendations of the Indiana State Board of Health relative to the reporting of serological tests. These recommendations are:

(a) To apply only Mazzini and Wassermann tests to routine diagnostic blood specimens.

(The Venereal Disease Committee feels that if a Mazzini screening test is negative, the specimen may be reported as negative to the physician without further diagnostic tests. Where the screening test is doubtful or positive, then the committee feels that both a Mazzini and Wassermann test should be performed, as suggested by the State Board of Health.)

(b) The State Board of Health recommends that routine serological tests be reported as "positive," "doubtful," or "negative," rather than 4 plus, 3 plus, 2 plus, etc.

(c) The State Board of Health recommends that the current procedure of handling spinal fluids be continued without change.

2. The Venereal Disease Committee recommends that the State Board of Health furnish penicillin for treatment of indigent cases of gonorrhea and primary and secondary syphilis. Such treatment is to be given at the place designated by the health officer having jurisdiction.

3. The Venereal Disease Committee vigorously condemns the plan proposed by the State and Territorial Health Officers Association, which advocates that all cases of syphilis be referred to a rapid treatment center, with the physician who made the diagnosis being paid a fee for such referral.

The committee opposes this action because rapid massive treatment has not been proved to be efficient.

The committee opposes this action because there is no satisfactory system of follow-up of treated cases.

The committee feels that the community will be better served by treating the patients until complete recovery has occurred, rather than to concentrate only on temporary removal of the infectious state.

4. The Venereal Disease Committee recommends that a diligent follow-up be made in every case of gonorrhea and syphilis. Each will thereby benefit to the fullest extent by modern treatment.

F. R. N. Carter, M.D., *Chairman,*
Sam W. Litzenberger, M.D.,
W. W. Hewins, M.D.,
W. P. Morton, M.D.,
E. O. Nay, M.D.,
Robert G. Moore, M.D.,
Minor Miller, M.D.,
J. S. Reynolds, M.D.,
Ernest Rupel, M.D.,
Robert L. Amos, M.D.,
T. R. Hayes, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Industrial Health submits the following report of its activities for the past year.

A meeting of the committee was held at French Lick in October, 1945, with Dr. W. D. Gatch, of Indiana University; Dr. Carl Peterson, of the American Medical Association; and Dr. Harold Vonachen, of the Caterpillar Tractor Company, as guests.

At that time it was thoroughly discussed and agreed by the committee that Indiana University should institute some courses in industrial medicine and surgery. It was the opinion of the committee that a chair on industrial medicine and surgery be included in the curriculum. However, Dr. Gatch advised that the curriculum was so crowded that he thought it would be impossible to add to it at that time. He did say some industrial medicine courses would be instituted in the Department of Public Health, which had recently been established. This, the committee felt would be quite a step forward, even though we were unable to accomplish all we had planned in this respect.

It was again discussed and recommended by the committee that each district of the state organization have at least one meeting a year devoted to industrial medicine and surgery. In the discussion it was brought out that it might be more advantageous for each district to decide the type of meeting they would prefer, rather than have a meeting outlined by the state committee. However, we suggested a meeting be held in an industrial plant and invite the doctors, or arrange for a meeting of the county society and invite the industrialists. Both types of meetings have been held in the past and have worked out very nicely. The committee very highly recommends either type of meeting.

A very lengthy discussion was held regarding a new waiver law. It was recommended that an attempt be made to place a waiver law back on the statutes which would be so thorough and complete that it would again be possible for industry to employ physically-handicapped individuals without jeopardizing themselves or the prospective employees.

Another meeting of the committee was held on May 5, 1946, in Indianapolis, with Mr. H. Ken-

ney, chairman of the State Legislative Bureau, and Dr. Harold R. Hennessy, of the American Medical Association, as guests.

The proposed new waiver law was discussed quite at length with Mr. Kenney, and we were advised that a bill had been, or was being, drawn up.

Dr. Hennessy gave us some very good suggestions and was very helpful. He was quite interested in our meeting and what Indiana had been doing industrially.

We were advised that Indiana University had arranged to give four clock hours devoted to industrial medicine in the new School of Public Health. The committee felt that as a starter this would be very worth while and thus partially achieved its objective outlined at the French Lick session.

Due to some unfortunate circumstances over which the committee had no control, the two-day postgraduate course in industrial medicine could not be held this year. In lieu of this the committee recommended a program to the state committee for the fall meeting. The program committee of the state medical association did not concur in this thought. However, it is still the committee's opinion that the two-day postgraduate course is a very valuable course and should be continued if at all possible.

We are very sorry to hear that Dr. Thomas Dobbins, of Evansville, is changing his position. This will mean a loss to the state society as well as the Industrial Health Committee, as he was a very active member of our committee, and we feel his assistance has been very valuable.

The chairman wants to take this opportunity of thanking all of the members of the Industrial Health Committee for their very valuable time and effort spent in helping with the various activities of the year.

E. S. Jones, M.D., *Chairman*,
H. M. Trusler, M.D.,
John Hilbert, M.D.,
L. W. Spolyar, M.D.,
W. R. Glock, M.D.,
E. B. Mumford, M.D.,
C. A. Weller, M.D.,
Thomas Dobbins, M.D.,
E. T. Stahl, M.D.,
F. M. Whisler, M.D.,
M. R. Davis, M.D.,
E. H. Carlton, M.D.

Mail reservations for Annual Banquet of Indiana Health Officers Association, to be held at 6:30 p.m., Monday, October twenty-eighth, to G. F. Kempf, M.D., City Hall, Indianapolis, Indiana.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Indiana Inter-Professional Health Council did not meet during the past year; therefore your committee has nothing to report at this time.

E. H. Clauser, M.D., *Chairman.*
A. P. Hauss, M.D.,
J. E. Ferrell, M.D.,
A. M. Mitchell, M.D.,
Norman M. Beatty, M.D.,
J. William Wright, M.D.

ANTI-TUBERCULOSIS COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

A meeting of the Anti-Tuberculosis Committee of the Indiana State Medical Association was held on Sunday, August 18, 1946, at the Columbia Club, in Indianapolis. Those present were: Drs. H. C. Ochsner, Indianapolis; H. W. Garton, Fort Wayne; Philip H. Becker, Crown Point; J. V. Pace, New Albany, and J. H. Stygall, Indianapolis. This was a joint meeting with the Indiana Chapter of the American College of Chest Physicians, and Murray A. Auerbach, executive secretary of the Indiana Tuberculosis Association, and Dr. Merle Bundy, acting director of Tuberculosis of the Indiana State Board of Health, were guests.

A general discussion of "mass x-ray surveys" was held. Dr. Bundy reported on the proposed x-raying of State Fair visitors by the Indiana State Board of Health. No case would be x-rayed without the name of a family physician given. The report of the x-ray would be sent to the family physician. It was agreed that an outline of follow-up procedure would be enclosed with each x-ray report. This procedure would be under the letterhead of the Indiana Tuberculosis Association, and would read as follows:

"A miniature x-ray unit was made available at the State Fair to those who wanted a chest x-ray. As your name was given as the doctor to whom the report should be sent, we enclose this report, which shows definite x-ray findings in the chest.

"Case finding by miniature x-rays in hunting for active tuberculosis is gaining importance as the days go by. However, the overall picture of tuberculosis control cannot keep pace unless the follow-up of these surveys is improved. With this in mind the Tuberculosis Committee of the state medical association recommended to the Indiana Chapter of the American College of Chest Physicians that a committee set forth what these chest specialists believe to be an adequate examination of the individuals who are found to have pulmonary path-

ology compatible with findings in tuberculosis. This committee's recommendations involve some procedures which you may not be able to perform in your office. They are, however, suggestions which will enable you to evaluate more adequately the clinical status of your patients.

"1. (a) An adequate history and physical examination.
(b) 14 x 17 Roentgenogram, preferably stereoscopic.
"2. (a) At least six concentrated sputum examinations.
(b) Temperature study.
(c) Blood count and sedimentation rate, if possible.

"These recommendations have been approved by the Tuberculosis Committee of the Indiana State Medical Association, the Indiana Chapter of the American College of Chest Physicians, the Indiana Trudeau Society, and the Indiana Tuberculosis Association.

"Your cooperation is appreciated."

J. H. Stygall, M.D., *Chairman,*
Philip H. Becker, M.D.,
R. B. Sanderson, M.D.,
L. C. Marshall, M.D.,
H. W. Garton, M.D.,
Robert O. Scott, M.D.,
H. C. Ochsner, M.D.,
J. V. Pace, M.D.

COMMITTEE ON CONSERVATION OF VISION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Committee on Conservation of Vision sponsored the subject matter of the May issue of The Journal, which featured articles on conservation of vision, prevention of blindness, and topics pertaining to ophthalmology in general, with special consideration of problems likely to be met by the general practitioner.

The committee decided that it would be inexpedient to attempt to have a Conservation of Vision Breakfast at the time of the state meeting in 1946.

C. W. Rutherford, M.D., *Chairman.*
O. T. Allen, M.D.,
M. G. Erehart, M.D.
Eugene L. Bulson, M.D.,
H. Brooks Smith, M.D.

POSTWAR COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

It has not been necessary to call a formal meeting of the Postwar Committee. The activities have been largely the aftermath of the Procurement and Assignment Service; they have been many, but in no instance has any action been taken on a matter that should have been considered by the committee as a whole. It is not practicable to reduce to formal writing details demanding attention. Often they have related to and interlocked with responsibilities of other state association committees. There have been in excess of one hundred interviews during the year 1946, also considerable correspondence relating to new locations, relocations, housing, residencies, hospital appointments, relationships as between the returned medical officer and the community or between the medical officer and county societies, and assistance in establishing attending staff eligibility in hospitals. In one instance a group of thirty medical officers doing residencies under the GI Bill of Rights had received no government check for four months; within ten days we had the answer.

We are glad to report that a great many young men are locating in communities where they are needed, and in every instance they are being highly successful. This means that gradually rural districts again will be provided with adequate medical care.

It is recommended for 1947 that this committee be consolidated with an existing association committee.

C. R. Bird, M.D., *Chairman.*,
Carleton B. McCulloch, M.D.
Glen Ward Lee, M.D.
Joseph L. Allen, M.D.
C. V. Rozelle, M.D.
B. W. Chidlaw, M.D.

COMMITTEE ON PHYSICAL THERAPY

(No report submitted.)

MEDICAL RELIEF COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Medical Relief Committee has received no requests for action on any controversial matter. Therefore, there is no new business to be reported for the year 1945-1946. Likewise, there is no supplement to the report printed in The Journal of September, 1945.

Eugene F. Boggs, M.D., *Chairman.*
L. B. Rariden, M.D.
James L. Wyatt, Jr., M.D.
Claude S. Black, M.D.
Alfred Ellison, M.D.
Austin Sweet, M.D.
K. L. Hull, M.D.
John D. Van Nuys, M.D.

COMMITTEE ON RURAL MEDICAL CARE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your committee is proud to report that it has made definite progress toward some solution of the tremendous problem of adequate medical care for those who live in the suburban areas of our state.

The step-by-step progress toward this goal follows:

March 30th—The committee attended the first annual Rural Health Conference at Chicago. This conference was conducted by the Committee on Rural Medical Service of the A.M.A. The purpose of this meeting was to determine what had been accomplished by the various State Committees on Rural Health.

April 7th—The first joint meeting of the Committees On Rural Medical Care of the Indiana State Medical Association and the Hoosier Farm Bureau was held at Indianapolis. Those present included committee members, Dr. L. E. Burney, state health commissioner; Dr. F. S. Crockett, chairman of the Committee on Rural Medical Service of the A.M.A.; and Hassil E. Schenck, president of the Indiana State Farm Bureau. During this meeting the groundwork was laid for a state-wide conference of medical and agricultural leaders to discuss the problems of rural medical care at Purdue University.

May 26th—The second joint meeting was held at Indianapolis. This meeting was attended by committee members and Harry J. Reed, dean of the Purdue School of Agriculture, Dr. L. E. Burney, Dr. J. E. Ferrell, president of the Indiana State Medical Association, and Mr. Robert Yoho, director of Health Education of the Indiana State Board of Health.

Possible subjects and speakers were considered for the conference. It was decided to discuss the following subjects at the conference:

Pending Federal Legislation.
Indiana's Public Health Program.
Farm Health Needs.
Dental Health Needs.
Memorial Health Centers.

It was agreed that the entire idea of the conference would be to get the farm people to realize that these are their problems.

It was also hoped that the local farm groups would appoint a County Health Committee to carefully study their own problems in their individual counties.

Report of Purdue Conference

The Rural Medical Care Conference was held at Purdue University, August first. The conference was attended by two hundred farm people.

Dr. F. S. Crockett, chairman on Rural Medical Service of the American Medical Association, presided at the meeting. He did a splendid job. The President of Purdue University, F. L. Hovde, gave the Welcome Address. Dean Harry J. Reed gave the response.

Dr. Thurman B. Rice, of Indianapolis, gave a talk on "Health Needs in Indiana." He made a fiery talk and used charts to bring out his points. One point he stressed was that we cannot have a healthy state unless the health department has more money to work with.

Mr. Wray Fleming's talk was right to the point on "Pending Federal Legislation." He explained what would happen if these laws were passed.

Dr. Jesse E. Ferrell, who is president of the Indiana State Medical Association, gave a splendid talk on "Rural Health Needs."

Roy Smiley, D.D.S., of Washington, Indiana, very ably presented a talk on "Rural Dental Needs."

In the afternoon, Mr. Wilbur Young, of Osgood, assistant superintendent of Public Instruction for Indiana, discussed "School Health Needs in Rural Areas." He stressed ways to make our rural schools better.

Miss Margaret C. Klem, Washington, D.C., is chief of the Medical Economics Section of the Division of Health and Disability Studies of the Social Security Board. She discussed "What Other States Are Doing," and told of the different plans of health insurance.

Dr. L. E. Burney, State Health Commissioner of Indiana, gave a talk on "Public Health Plans for Rural Areas." His talk was well presented. Dr. Burney told of an ideal health program in which there would be one full-time public health doctor in each county.

Mr. Anson S. Thomas, director of Tax and Legislation of the Indiana Farm Bureau, Inc., made a very interesting talk on "Rural Health Centers as Memorials." This paper was ably presented.

The conference was summarized by Dean Harry J. Reed, of Purdue University.

The meeting attracted Dr. Norman H. Gardner, of East Hampton, Connecticut, chairman of the Rural Medical Service Committee of the Connecticut State Medical Society, and Dr. Harlan English, of Danville, Illinois, chairman of the Rural Medical Service Committee of the Illinois State Medical Society, who were there to learn what Indiana is doing on the subject.

At the conclusion of the program the farm leaders were requested to organize health committees in their respective counties and to make a study of their health needs. Another conference will be held at which time these reports will be studied, and a program for solving the various problems will be developed.

Your committee believes that the problem of rural medical care is more clearly understood than a year ago, and that we are definitely on the way to finding some workable solution through coopera-

tion with the agricultural leaders and public health officials.

H. N. Smith, M.D., *Chairman*,
I. H. Scott, M.D.,
Stuart R. Combs, M.D.,
George A. May, M.D.,
George R. Douglas, M.D.,
George V. Cring, M.D.

COMMITTEE ON HARD OF HEARING

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Committee on Hard of Hearing has expressed the thought before, that "nothing isolates mankind from civilization and his fellow men more than the loss of hearing." Again, we wish to emphasize this, more particularly in reference to children. The lack of hearing during a child's developmental and educational period soon retards the child, making him appear queer, followed by an inferiority attitude. If this transition is detected early and corrected, it is amazing how soon the child regains his place in civilization. As a rule, however, this complete cycle does not take place within a year.

After discovering that this process is in operation the remedy consists of a front seat in school, perhaps on one side rather than the other; lip reading; special classes for the hearing handicapped; hearing aid; or residence in a school for the hard of hearing, all depending upon the amount of loss. Other than the hearing aid, these readjustments fall upon the public school system.

This committee is in accord that the detection and correction of hard of hearing is far underdeveloped and underpublicized. The advancement will be slow, however, due to the size of the task.

The state law passed a few years ago, requiring an annual audiometer test for all school children, was done in an attempt to detect early loss. This law has turned out to be a handicap since it cannot be carried out properly without sacrificing other health measures which are pertinent. Also the school system has had difficulty accommodating itself to so rapid a change. The medical profession in general has been too busy with broken arms and pneumonias to give proper attention to the hearing handicapped. So far as this committee can find out, this law was passed without consultation or advice from the health boards, school system, or medical profession.

In order to make possible other health measures, your committee has made the following report to the State Health Commissioner. "The reaction of this committee is that unnecessary time and energy is exerted each year in complying with this law. If the audiometer tests are to be continued we would recommend that they be limited to the first, fourth, and seventh grades, and we feel that as much would be accomplished as if they were done every year."

J. Kent Leasure, M.D., *Chairman*,
O. T. Allen, M.D.,
E. E. Holland, M.D.,
M. G. Erehart, M.D.,
B. D. Ravdin, M.D.,
K. L. Craft, M.D.,
H. C. Parker, M.D.,
Robert M. Dearmin, M.D.

COMMITTEE ON POSTWAR MEDICAL SERVICE

(No report received.)

COMMITTEE ON MEDICAL ECONOMICS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Committee on Medical Economics would like to recommend the following:

1. That there be an increased amount of emphasis given at the Indiana University School of Medicine to courses in economics.

2. That one meeting of each county medical society be devoted to economic problems connected with the practice of medicine. The American Medical Association can and will furnish speakers for such meetings. Mr. F. G. Dickinson has just been made the head of this department of the American Medical Association.

3. That the House of Delegates of the Indiana State Medical Association go on record as favoring the publication of a volume similar to *The Medical Blue Book* of Wisconsin; this to cover common laws applying to physicians, simplified income tax rulings, estate and inheritance taxes, and other matters of common interest to physicians. Some articles have appeared in The Journal along these lines, by Albert Stump, but we feel that the whole field should be covered in one volume.

W. H. Howard, M.D., *Chairman*,
A. C. Yoder, M.D.,
J. H. Weinstein, M.D.,
Clay Ball, M.D.,
W. J. Rissing, M.D.,
W. W. Holmes, M.D.,
E. L. VanBuskirk, M.D.,
O. A. Turner, M.D.,
Byron K. Rust, M.D.

MEDICAL ADVISORY COMMITTEE FOR VOCATIONAL REHABILITATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Medical Advisory Committee for Vocational Rehabilitation has had two meetings, the first to go over the entire setup and its coordination with federal regulations, which was worked out most successfully by Dr. Carl Martz, to whom your committee gives full credit for a splendid job.

Because of the resignation of Dr. Martz as the Supervisor of Physical Restoration and Medical Administrative Consultant, your committee met in Dr. Malan's office with a view of lending its advice in the selection of a successor. At this meeting your committee recommended the appointment of Dr. Frank M. Hall, who was later properly appointed and who is doing excellent work.

So that the doctors may know something of the workings of this department, we wish to submit a report of its operations for July, which is as follows:

		Total
1. Hearing Handicaps:		
a. Hearing aids	2	2
2. Orthopedic Handicaps:		
a. Rehabilitation corrective surgery	9	
b. Artificial limbs	14	
c. Braces and support	10	33
3. Respiratory Handicaps:		
a. Tuberculosis, pulmonary	9	9
4. Cardiovascular Handicaps:		
a. Rheumatic heart disease	3	3
5. Visual Handicaps:		
a. Corneal transplant	1	
b. Glass eye prosthesis	2	
c. Glasses	3	6
6. Miscellaneous Physical Handicaps:		
a. Hernia	2	
b. Diabetes, mellitus	2	
c. Gastro-intestinal	1	
d. Gynecological	1	
e. Genito-urinary	1	7
7. Neurological Handicaps:		
a. Epilepsy	3	
b. Cerebral palsy	5	8
8. Mentally Retarded Handicaps:		
a. Occupational potentialities	2	
b. Personality characteristics	3	
c. Social characteristics	3	8
9. Emotional Handicaps:		
a. Psychiatric	2	2
Grand Total		78

SUMMARY

Completed vocational rehabilitation cases reviewed:		Total
1. Number of cases found eligible	68	
2. Number of cases found non-feasible:		
a. For causes too trivial	5	
b. For causes to severe	2	75
Completed blind rehabilitation cases reviewed:		
1. Number of cases found eligible	19	
2. Number of cases found non-feasible	0	19
Grand Total		94
Total number of completed case evaluations		94
Total number of physical restoration services		78

Eighty-seven cases were found to be vocationally handicapped and vocational training or physical restoration services were offered.

Seven cases were rejected by reason of non-feasibility.

Note: The majority of physical restoration services were purchased and sponsored by Vocational Rehabilitation and Blind Rehabilitation. In a few cases these services were furnished by other state and local welfare agencies. Several minor services were purchased by the clients.

The members of this committee have responded to the calls for meetings, and are showing genuine interest in trying to carry their function to a creditable service.

JOHN H. HEWITT, M.D., *Chairman,*
BERT E. ELLIS, M.D.,
RAY ELLEDGE, M.D.,
MYRON S. HARDING, M.D.,
ROBERT B. ACKER, M.D.,
E. VERNON HAHN, M.D.,
KEITH T. MEYER, M.D.,
RICHARD L. HANE, M.D.,
FRANK M. GASTINEAU, M.D.,
JAMES O. RITCHEY, M.D.,
JAMES F. BALCH, M.D.

CENTENNIAL CELEBRATION COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

At the last annual session the House of Delegates of the Indiana State Medical Association appropriated enough money to enable this committee during its second year's existence to definitely plan for a "Memorial Volume" to be printed in 1949. We secured the services of Mrs. Dorothy Russo, of Indianapolis, as Editor-in-Chief, and she is well qualified because of her experience in historical writing and her great interest in this particular subject.

We already have authors writing on three different chapters, and the material is well in hand. At our recent committee meeting we decided to include chapters on the allied professions of Dentistry, Nursing, and Pharmacy. If this report is adopted, we will take it as a directive to continue the services of Mrs. Russo for another year, and we hope by that time to have the book fairly well completed.

In the meantime, we have asked the members of the association to remember this committee's task, and help to secure the essential medical history of every county in the state.

CHARLES N. COMBS, M.D., *Chairman,*
EDGAR F. KISER, M.D.,
L. G. ZERFAS, M.D.,
MINOR MILLER, M.D.,
F. A. MALMSTONE, M.D.,
O. B. NESBIT, M.D.,

(Continued on next page)

(Continued from preceding page)

V. L. Turley, M.D.,
G. Irene Polhemus, M.D.,
J. B. Maple, M.D.,
W. N. Wishard, Jr., M.D.,
John Iddings, M.D.

REPORT OF BUILDING COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Building Committee had a meeting with the Building Committee of the Indianapolis Medical Society on January 27, 1946. At this meeting a discussion of location, probable cost and proportionate share of expense to the Indiana State Medical Association and the Indianapolis Medical Society were discussed.

Inasmuch as there has been no definite site selected by the Indianapolis Medical Society, and inasmuch as the state association has for the time being a suitable, centrally-located place, at reasonable rent, we, your committee, feel that it would be unwise to spend a large sum of money for a building at this time.

Paul A. Garber, M.D., *Chairman,*
Minor Miller, M.D.,
Oran A. Province, M.D.

COMMITTEE ON ESTABLISHMENT OF THE BOARD OF CERTIFICATION FOR THE GENERAL PRACTICE OF MEDICINE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your committee, consisting of one member from each Councilor District, one member representing the Indiana University School of Medicine, and one member representing the Indiana State Medical Association was named by Dr. N. K. Forster, then president of the Indiana State Medical Association, December 20, 1945, and continued by Dr. J. E. Ferrell, president this year. The first meeting was held on January 27, 1946, at which time the structure of other specialty boards was studied and definite plans approved for the formation of the Board. The committee concurred in the employment of Mr. Albert Stump as attorney.

At the next meeting, April 28, 1946, By-Laws and the incorporation of the Board under the Not-For-Profit Corporation Laws of Indiana were approved. At this time the board was formed, and officers and committee members were elected. This report may be found in the June, 1946, issue of The Journal of the Indiana State Medical Association.

Your committee wishes to report that on June 23, 1946, the "Committee on Qualifications" and the officers of the board met and approved pending applications for the Founders Group. Their decision was to hold the Founders Group open an indefinite period for the applications of outstanding general practitioners, and then closing this Founders Group in the not too distant future.

General practitioners interested in taking the examination for admittance may obtain Bulletin of Information and application blank from the State Headquarters of the Board, at 1021 Hume Mansur Building, Indianapolis 4.

It is further learned that the board has made arrangements to hold half-day clinical meetings at the Indiana University Medical Center every month. Each meeting will cover one subject and will consist of an hour's lecture, three-hour clinical demonstrations and practical applications, and a one-hour discussion. In addition, the board wishes to encourage the development of Residencies in General Medicine in many of the qualified hospitals throughout the state.

H. E. Klepinger, M.D., *Chairman,*
O. M. Graves, M.D.,
J. T. Oliphant, M. D.,
James W. Baxter, Jr., M.D.,
F. A. Streck, M.D.,
D. A. Gerrish, M.D.,
Robert W. Gehres, M.D.,
Eugene Boggs, M.D.,
Clay Ball, M.D.,
John Iddings, M.D.,
R. W. Lavengood. M.D.,
M. R. Lohman, M.D.,
C. M. Sennett, M.D.,
C. G. Culbertson, M.D.,
J. E. Ferrell, M.D.

VETERANS' AFFAIRS COMMITTEE

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The following resolution was presented to the House of Delegates and the Council of the Indiana State Medical Association, and was accepted by motion on December 16, 1945:

Whereas, The problems of the medical officer returning to civilian practice or the completion of his graduate training at the time of separation from active duty present problems which only organized medicine, as represented by the Indiana State Medical Association and the American Medical Association and their component parts can solve, and

Whereas, these problems are acute, requiring prompt action, therefore be it Resolved:

1. That, the House of Delegates of the Indiana State Medical Association establish a Servicemen's

Section, the membership of which will consist of those men separated from service with the armed forces and registered at French Lick during the 1945 annual meeting and members of the American Medical Association in good standing who return to the State of Indiana and become members of the Indiana State Medical Association.

2. That, the Committee on Post-War Medical Service of the Indiana State Medical Association provide a means of registration for medical officers returning from the armed services, and a special service and information to such registrants through the Executive Office of the Indiana State Medical Association.

3. That, the County Committee of Procurement and Assignment Service in each county be responsible for prompt assistance in procuring adequate office space and residence for physicians returning to former locations from the armed forces.

4. That, the Indiana State Medical Association establish a loan fund from its reserve fund, or similar funds, for the benefit of physicians returning from the armed services.

5. That, the Post-War Medical Service Committee of the Indiana State Medical Association increase the facilities for completion of graduate training, interrupted by service in the armed forces, in institutions in the State of Indiana, recognized by the American Medical Association by means of:

(a) Assistant residencies financed according to provisions of the GI Bill of Rights and not increasing the budget of such institutions.

(b) Supplement the residencies above by a schedule of assistancies in the offices of qualified physicians.

(c) A plan to provide housing and adequate shelter for the families of physicians participating in such training.

6. That, a resolution be presented to the Board of Trustees of the American Medical Association for civilian consultants to the medical services of the Army, the Navy, and the Veterans Administration for the purpose of providing maximum and efficient medical care to members of the armed forces at the time of war, and to utilize the skill of medical officers to the greatest advantage by assignments according to the special training of such officers and distribution of medical officers in a manner to avoid the loss of such skill in replacement depots and officer pools.

Only one loan has been made to a member of the association under such a plan.

Charles F. Thompson, M.D., *Chairman*,
Dillon D. Geiger, M.D.,
Ralph Leser, M.D.,
Harold F. Zwick, M.D.,
A. N. Ferguson, M.D.,
Russell L. Malcolm, M.D.,
Dallas Fickas, M.D.

COMMITTEE ON STATE FAIR

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The exhibit:

The six famous Wyeth paintings depicting famous milestones in American Medicine.
The A.M.A.'s new "Ten Point Plan" for medical care of the American public.
The A.M.A.'s "Medical Question Box."
Blood Pressure Determinations—two stations. (Instruments, courtesy Curtis & French.)
Determination of Color Blindness.
Determination of Depth Perception. (Instruments furnished by the United States Army Air Corps and the United States Navy.)

At an invitation of the committee, the following organizations shared display space in the West State Board of Health Building:

Indiana Cancer Society.
Indiana State Dental Association.
Indiana Pharmaceutical Association.
Indiana Tuberculosis Association.
National Foundation for Infantile Paralysis.
Mutual Medical Insurance, Inc.
Indiana State Nurses' Association.
Indiana Council for Mental Health.

Through the cooperation of Mr. Robert Yoho, of the Indiana State Board of Health, and Mr. Ray E. Smith, executive secretary of the Indiana State Medical Association, the exhibit area was quickly and attractively arranged.

The following examinations performed by the members of the committee, assisted by Messrs. Porter, Pierce, and Hauk, medical students, set a new record:

Depth Perception	2,520
Color Vision	3,062
Color-blind	38 (1.2%)
Blood Pressure	4,260
Females	2,910
Males	1,350
Average age	26 years
Average reading	132/66
Highest reading (Female, aged 48)	296/148
Lowest reading (Female, aged 9)	76/58
Abnormal Systolics Basis 155 mm. Hg.	752 (18% of total)
Abnormal Diastolics Basis 100 mm. Hg.	793 (19% of total)
Total Examinations Recorded	9,842

Small cards were given all abnormals to be taken to their family physicians for further study.

R. H. Wisehart, M.D., *Chairman*,
C. G. Kern, M.D.,
R. V. Pearce, M.D.,
M. B. Ferrell, M.D.,

(Continued on next page)

(Continued from preceding page)

D. J. Steele, M.D.,
Loren Martin, M.D.,
H. W. Beaver, M.D.,
J. L. Sims, M.D.

COMMITTEE FOR MEDICAL CARE TO VETERANS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

In accordance with action by the House of Delegates, on January 27, 1946, a plan and data upon which a fee schedule might be compiled were submitted to the officers of the county societies of the state association on February 15, 1946. The composite plan and fee schedule were accepted by motion of the Council of the association on April 14, and, after minor changes, again on July 21, 1946, and finally by the Veterans Administration on August 30, 1946.

The agreement is published on page 577 of this issue of The Journal. The fee schedule and request to participate in the plan have been mailed to each member of the association.

The agreement with the Veterans Administration and the fee schedule are included as a part of the report of this committee.

Charles F. Thompson, M.D., *Chairman*,
William H. Garner, M.D.,
A. S. Giordano, M.D.,
Frank B. Ramsey, M.D.,
Vance J. Chattin, M.D.

COMMITTEE ON PREVENTION OF TRAFFIC ACCIDENTS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Traffic Safety Committee of the Indiana State Chamber of Commerce sponsored one of the weekly programs entitled, "Speak Up Indiana," over WIBC, on which the chairman of your committee appeared. Dr. Frank Forry of the Indiana University School of Medicine, Dr. Paul Evans, assistant superintendent of the Indianapolis City Hospital, and Dr. Roy B. Storms, Marion County coroner, also participated in this program.

N. M. Hadley, M.D., *Chairman*,
Glen W. Lee, M.D.,
J. C. Glackman, Jr., M.D.,
R. N. Washburn, M.D.,
R. M. LaSalle, M.D.

COMMITTEE ON REVISION OF THE CONSTITUTION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your committee met at Indianapolis on August 18, 1946, those in attendance being Drs. George V. Cring, O. E. Wilson, and A. W. Cavins. Dr. W. D. Gatch was also present, at the invitation of the committee.

Your committee feels that the general plan of organization of medicine in this state is entirely in agreement with American principles of representative government, and actually provides a greater degree of "home rule" than exists in our civil government. Therefore, the committee considered that a new constitution for the Indiana State Medical Association is not needed and not indicated.

However, the possibilities of ensuring greater participation by the individual physician and by the component county societies in the affairs of the state association were carefully discussed, and your committee recommends the following:

That the Constitution be amended as follows, to wit: that ARTICLE IX—Section 4 be deleted and replaced by the following new Section 4: The Councilors shall be elected by the respective district societies, provided that if any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Regarding the amendment to the Constitution, your committee would point out that by ARTICLE IX, Section 2, Councilors serve until their successors are elected, and there is actually no reason for the rather undemocratic procedure of having the House of Delegates elect any Councilor at any time. Since the Councilor represents his district in a most important capacity as member of the Council, your committee feels that under no circumstances should any Councilor be elected by other than his own constituency. In case of the death or permanent incapacity of a Councilor, the procedure provided for such contingency by the Constitution and By-Laws of that district society should be applied by its officers.

A. W. Cavins, M.D., *Chairman*,
George V. Cring, M.D.,
O. E. Wilson, M.D.,
E. L. Libbert, M.D.,
Cleon A. Nafe, M.D.

These annual reports will give you a cross-section of what goes on in Indiana Medicine—read them.

LIST OF PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Name and Residence	Elected	Served
*Livingston Dunlap, Indianapolis	1849	1849
*William T. S. Cornett, Versailles	1849	1850
*Ashahel Clapp, New Albany	1850	1851
*George W. Meaks, Indianapolis	1851	1852
*Jeremiah H. Blower, Lawrenceburg	1852	1853
*Elizur H. Deming, Lafayette	1853	1854
*Madison J. Bray, Evansville	1854	1855
*William Lomax, Marion	1855	1856
*Daniel Meeker, LaPorte	1856	1857
*Talbot Bullard, Indianapolis	1857	1858
*Nathan Johnson, Cambridge City	1858	1859
*David Hutchinson, Mooresville	1859	1860
*Benjamin S. Woodworth, Fort Wayne	1860	1861
*Theophilus Parvin, Indianapolis	1861	1862
*James F. Hibbard, Richmond	1862	1863
*John Sloan, New Albany	1863	1864
*John Moffett (acting), Rushville	1864	1864
*Samuel M. Linton, Columbus	1864	1865
*Wilson Lockhart (acting), Danville	1865	1865
*Myron H. Harding, Lawrenceburg	1865	1866
*Vierling Kersey, Richmond	1866	1867
*John S. Bobbs, Indianapolis	1867	1868
*Nathaniel Field, Jeffersonville	1868	1869
*George Sutton, Aurora	1869	1870
*Robert M. Todd, Indianapolis	1870	1871
*Henry P. Ayres, Fort Wayne	1871	1872
*Joel Pennington, Milton	1872	1873
*Isaac Casselbery, Evansville	1873	.....
*Wilson Hobbs, Knightstown	1873	1874
*Richard E. Houghton, Richmond	1874	1875
*John H. Helm, Peru	1875	1876
*Samuel S. Boyd, Dublin	1876	1877
*Luther D. Waterman, Indianapolis	1877	1878
*Louis Humphreys, South Bend	1878	.....
*Benj. Newland (acting), Bedford (v.-p.)	1878	1879
*Jacob R. Weist, Richmond	1879	1880
*Thomas B. Harvey, Indianapolis	1880	1881
*Marshall Sexton, Rushville	1881	1882
*William H. Bell, Logansport	1882	1883
*Samuel E. Munford, Princeton	1883	1884
*James H. Woodburn, Indianapolis	1884	1885
*James S. Gregg, Fort Wayne	1885	1886
*General W. H. Kemper, Muncie	1886	1887
*Samuel H. Charlton, Seymour	1887	1888
*William N. Wishard, Indianapolis	1888	1889
*James D. Gatch, Lawrenceburg	1889	1890
*Gonsolvo C. Smythe, Greencastle	1890	1891
*Edwin Walker, Evansville	1891	1892
*George F. Beasley, Lafayette	1892	1893
*Charles A. Daugherty, South Bend	1893	1894
*Elijah S. Elder, Indianapolis	1894	.....
Charles S. Bond (acting), Richmond	1894	1895
*Miles F. Porter, Fort Wayne	1895	1896
*James H. Ford, Wabash	1896	1897
*William N. Wishard, Indianapolis	1897	1898
*John C. Sexton, Rushville	1898	1899
*Walker Schell, Terre Haute	1899	1900
*George W. McCaskey, Fort Wane	1900	1901
*Alembert W. Brayton, Indianapolis	1901	1902
*John B. Berteling, South Bend	1902	1903
*Jonas Stewart, Anderson	1903	1904
*George T. MacCoy, Columbus	1904	1905
*George H. Grant, Richmond	1905	1906
*George J. Cook, Indianapolis	1906	1907
*David C. Peyton, Jeffersonville	1907	1908
*George D. Kahlo, French Lick	1908	1909
*Thomas C. Kennedy, Shelbyville	1909	1910
*Frederic C. Heath, Indianapolis	1910	1911
*William F. Howat, Hammond	1911	1912
*A. C. Kimberlin, Indianapolis	1912	1913
*John P. Salb, Jasper	1913	1914
*Frank B Wynn, Indianapolis	1914	1915
*George F. Keiper, Lafayette	1915	1916
*John H. Oliver, Indianapolis	1916	1917
*Joseph Rilus Eastman, Indianapolis	1917	1918
William H. Stemm, North Vernon	1918	1919
*Charles H. McCully, Logansport	1919	1920
*David Ross, Indianapolis	1920	1921
William R. Davidson, Evansville	1921	1922
*Charles H. Good, Huntington	1922	1923
*Samuel E. Earp, Indianapolis	1923	1924
E. M. Shanklin, Hammond	1924	1925
Charles N. Combs, Terre Haute	1925	1926
*Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1926	1928
Charles E. Gillespie, Seymour	1927	1929
*Angus C. McDonald, Warsaw	1928	1930
Alois B. Graham, Indianapolis	1929	1931
Franklin Smith Crockett, Lafayette	1930	1932
Joseph H. Weinstein, Terre Haute	1931	1933
Everett E. Padgett, Indianapolis	1932	1934
*Walter J. Leach, New Albany	1933	1935
Roscoe L. Sensenich, South Bend	1934	1936
*Edmund Dougan Clark, Indianapolis	1935	1937
Herman M. Baker, Evansville	1936	1938
Edmund M. Van Buskirk, Fort Wayne	1937	1939
Karl R. Ruddell, Indianapolis	1938	1940
Albert M. Mitchell, Terre Haute	1939	1941
M. A. Austin, Anderson	1940	1942
C. H. McCaskey, Indianapolis	1941	1943
J. T. Oliphant, Farmersburg	1942	1944
N. K. Forster, Hammond	1943	1945
J. E. Ferrell, Fortville	1944	1946

* *Deceased.*

DATA FROM PREVIOUS SESSIONS

Year	Session	Place	Registration
1908	59th	French Lick	312
1909	60th	Terre Haute	421
1910	61st	Fort Wayne	450
1911	62nd	Indianapolis	748
1912	63rd	Indianapolis	590
1913	64th	West Baden	312
1914	65th	Lafayette	527
1915	66th	Indianapolis	646
1916	67th	Fort Wayne	381
1917	68th	Evansville	270
1918	69th	Indianapolis	388
1919	70th	Indianapolis	.....
1920	71st	South Bend	421
1921	72nd	Indianapolis	550
1922	73rd	Muncie	522
1923	74th	Terre Haute	823
1924	75th	Indianapolis	1,012
1925	76th	Marion	800
1926	77th	West Baden	900
1927	78th	Indianapolis	1,500
1928	79th	Gary	892
1929	80th	Evansville	814
1930	81st	Fort Wayne	1,115
1931	82nd	Indianapolis	1,033
1932	83rd	Michigan City	904
1933	84th	French Lick	637
1934	85th	Indianapolis	1,814
1935	86th	Gary	1,011
1936	87th	South Bend	1,150
1937	88th	French Lick	1,154
1938	89th	Indianapolis	1,751
1939	90th	Fort Wayne	1,332
1940	91st	French Lick	1,064
1941	92nd	Indianapolis	1,890
1942	93rd	French Lick	706
1943	94th	Indianapolis	1,323
1944	95th	Indianapolis	1,584
1945	96th	French Lick	922
1946	97th	Indianapolis	.....

HOUSE OF DELEGATES, INDIANA STATE MEDICAL ASSOCIATION

INDIANAPOLIS, INDIANA

October 29, 30, and 31, 1946

Delegates	*Alternates*
ADAMS	
Ben Duke, Decatur	James Burk, Decatur
ALLEN	
Arnold Duemling, Ft. Wayne	H. Vaughn Scott, Ft. Wayne
M. B. Catlett, Ft. Wayne	C. B. Parker, Ft. Wayne
Milton Popp, Ft. Wayne	William R. Clark, Ft. Wayne
Maurice Glock, Ft. Wayne	Arthur Roser, Ft. Wayne
BARTHOLOMEW	
J. E. Dudding, Hope	L. F. Beggs, Columbus
BENTON	
V. L. Turley, Fowler	L. P. Muller, Boswell
BOONE	
C. O. Weddle, Lebanon	John R. Porter, Lebanon
CARROLL	
M. R. Adams, Flora	C. L. Wise, Camden
CASS	
Earl B. Jewell, Logansport	John C. Davis, Logansport
CLARK	
J. T. Carney, Jeffersonville	E. P. Buckley, Jeffersonville
CLAY	
J. Frank Maurer, Brazil	
CLINTON	
W. W. Jones, Frankfort	F. A. Beardsley, Frankfort
CRAWFORD	
DAVIESS-MARTIN	
A. G. Blazey, Washington	
E. B. Lett, Loogootee	
DEARBORN-OHIO	
W. J. Fagaly, Lawrenceburg	C. W. Olcott, Aurora
Charles Manley, Rising Sun	G. S. Fessler, Rising Sun
DECATUR	
H. S. McKee, Greensburg	J. T. Morrison, Greensburg
DEKALB	
C. B. Hathaway, Butler	Perry Reynolds, Garrett
DELAWARE-BLACKFORD	
C. A. Ball, Muncie	T. R. Owens, Muncie
Bruce W. Stocking, Muncie	J. W. Morris, Hartford City
DUBOIS	
S. L. McKinney, Huntingburg	M. C. Heck, Jasper
ELKHART	
A. C. Yoder, Goshen	James A. Work, Elkhart
S. T. Miller, Elkhart	I. J. Markel, Elkhart
FAYETTE-FRANKLIN	
Herman Smelser, Connersville	W. A. Kemp, Connersville
H. N. Smith, Brookville	E. M. Glaser, Brookville
FLOYD	
Wm. H. Garner, New Albany	Samuel Baxter, New Albany
FOUNTAIN-WARREN	
Lee J. Maris, Attica	
A. L. Patcliff, Kingman	

Delegates	*Alternates*
FULTON	
A. E. Stinson, Rochester	K. K. Kraning, Kewanna
GIBSON	
C. M. Clark, Oakland City	O. T. Brazelton, Princeton
GRANT	
Russell W. Lavengood, Marion	
GREENE	
King L. Hull, Bloomfield	H. B. Turner, Bloomfield
HAMILTON	
John S. Hash, Noblesville	Robert F. Harris, Noblesville
HANCOCK	
Joseph L. Allen, Greenfield	Lawrence B. Rariden, Greenfield
HARRISON	
William E. Amy, Corydon	
HENDRICKS	
O. T. Scamahorn, Pittsboro	J. C. Stafford, Plainfield
HENRY	
Walter M. Stout, New Castle	L. C. Marshall, Mt. Summit
HOWARD	
E. R. Clarke, Kokomo	H. M. Rhorer, Kokomo
HUNTINGTON	
G. M. Nie, Huntington	R. S. Galbreath, Huntington
JACKSON	
G. R. Gillespie, Brownstown	L. W. Elsner, Seymour
JASPER-NEWTON	
Harry English, Rensselaer	Jack Dick, Rensselaer
W. G. Pippenger, Brook	R. H. Ruhmkorff, Goodland
JAY	
George V. Cring, Portland	D. E. Spahr, Portland
JEFFERSON	
Anna Goss, Madison	O. A. Turner, Madison
JENNINGS	
D. W. Matthews, North Vernon	W. L. Grossman, North Vernon
JOHNSON	
Oran A. Province, Franklin	W. L. Portteus, Franklin
KNOX	
C. L. Boyd, Vincennes	Frederic Spencer, Vincennes
KOSCIUSKO	
LA GRANGE	
LAKE	
H. W. Eggers, Hammond	F. H. Mervis, East Chicago
J. R. Doty, Gary	J. P. Vye, Gary
C. M. Jones, Whiting	E. L. Schaible, Gary
G. L. Verplank, Gary	F. J. McMichael, Gary
P. Q. Row, Hammond	C. C. Brink, Gary
LAPORTE	
Jon Kelly, LaPorte	Thomas D. Armstrong, Michigan City

Delegates	*Alternates*
LAWRENCE	
Claude Dollens, Oolitic	B. A. Speheger, Bedford
MADISON	
C. V. Rozelle, Anderson	A. W. Elsten, Lapel
A .T. Jones, Pendleton	Perry Cotton, Elwood
MARION	
Eugene F. Boggs, Indianapolis	A. G. Funkhouser, Indpls.
Raymond C. Beeler, Indianapolis	Ross C. Ottinger, Indianapolis
George J. Garceau, Indianapolis	Thomas B. Noble, Jr., Indpls.
Ralph L. Lochry, Indianapolis	Edward F. Bloemker, Indpls.
Harry L. Foreman, Indianapolis	Harvey W. Sigmond, Indpls.
John M. Whitehead, Indianapolis	Glenn C. Lord, Indianapolis
William M. Dugan, Indianapolis	
Chester A. Stayton, Sr., Indpls.	
Bert E. Ellis, Indianapolis	W. Burleigh Matthew, Indpls.
Marlow W. Manion, Indianapolis	Roy Lee Smith, Indianapolis
Foster J. Hudson, Indianapolis	J. K. Berman, Indianapolis
James F. Balch, Indianapolis	Robert M. Moore, Indianapolis
Charles F. Thompson, Indpls.	Lyman T. Meiks, Indianapolis
Cleon A. Nafe, Indianapolis	Murray DeArmond, Indpls.
Clyde G. Culbertson, Indpls.	
Roy A. Geider, Indianapolis	
MARSHALL	
A. A. Thompson, Tyner	T. R. Possolt, Plymouth
MIAMI	
F. M. Lynn, Peru	Fred Malott, Converse
MONTGOMERY	
George A. Collett, Crawfordsville	Carl B. Parker, Wingate
MORGAN	
R. W. Van Bokkelen, Mooresville	H. H. Dutton, Martinsville
NOBLE	
J. R. Nash, Albion	C. E. Munk, Kendallville
ORANGE	
C. E. Boyd, West Baden Springs	John Spears, Paoli
OWEN-MONROE	
Julia Thom, Spencer	
William Karsell, Bloomington	Naomi Dalton, Bloomington
PARKE-VERMILLION	
F. G. Greene, Bloomingdale	J. R. Bloomer, Rockville
S. C. Darroch, Cayuga	A. F. Cohn, Clinton
PERRY	
N. A. James, Tell City	P. J. Coultas, Tell City
PIKE	
G. B. DeTar, Winslow	G. A. Dickinson, Petersburg
PORTER	
John R. Frank, Valparaiso	Wm. C. Butman, Hebron
POSEY	
J. Wm. Herr, Mount Vernon	J. R. Ranes, Mount Vernon
PULASKI	
C. E. Linton, Medaryville	G. H. McCaskey, Winamac
PUTNAM	
G. D. Rhea, Greencastle	D. J. Steele, Greencastle

Delegates	*Alternates*
RANDOLPH	
L. W. Painter, Winchester	
RIPLEY	
R. Lee Smith, Osgood	N. D. Moran, Versailles
RUSH	
R. B. Johnson, Rushville	Melvin Denny, Rushville
ST. JOSEPH	
A. S. Giordano, South Bend	Joseph Murphy, South Bend
C. M. Sennett, South Bend	M. J. Thornton, South Bend
F. R. N. Carter, South Bend	J. V. Cassady, South Bend
SCOTT	
Floyd S. Napper, Scottsburg	Marvin McClain, Scottsburg
SHELBY	
W. D. Inlow, Shelbyville	P. R. Tindall, Shelbyville
SPENCER	
J. H. Barrow, Dale	J. C. Glackman, Jr., Rockport
STARKE	
STEUBEN	
SULLIVAN	
C. F. Briggs, Sullivan	C. E. Whipps, Carlisle
SWITZERLAND	
L. H. Bear, Vevay	G. W. Copeland, Vevay
TIPPECANOE	
Earl Van Reed, Lafayette	Ramond R. Calvert, Lafayette
Gordon A. Thomas, Lafayette	O. L. McCay, Romney
TIPTON	
S. M. Cotton, Goldsmith	B. A. Burkhardt, Tipton
VANDERBURGH	
Paul D. Crimm, Evansville	C. W. Cullnane, Evansville
Clarence C. Herzer, Evansville	V. V. Schriefer, Evansville
	H. T. Combs, Evansville
VIGO	
M. C. Topping, Terre Haute	A. W. Cavins, Terre Haute
E. O. Nay, Terre Haute	W. C. Kunkler, Terre Haute
WABASH	
O. G. Brubaker, North Manchester	
WARRICK	
J. Guy Hoover, Boonville	R. E. Zwickel, Newburgh
WASHINGTON	
Frederick K. Allen, Salem	I. E. Huckleberry, Salem
WAYNE-UNION	
Harry P. Ross, Richmond	E. E. Holland, Richmond
Will A. Thompson, Liberty	J. F. Lewis, Liberty
WELLS	
Harold D. Caylor, Bluffton	H. Brooks Smith, Bluffton
WHITE	
Henry W. Greist, Monticello	J. P. Galbreth, Burnettsville
WHITLEY	
Paul A. Garber, South Whitley	B. F. Pence, Columbia City

EXHIBITORS

Booth Number	
1	SCHENLEY LABORATORIES, INC., Lawrenceburg, Ind., and New York, N.Y.
2	THE BORDEN COMPANY, New York, N.Y.
3	AMES COMPANY, INC., Elkhart, Ind.
4	THE MALTINE COMPANY, New York, N.Y.
5	THE PROCTER AND GAMBLE COMPANY, Ivorydale, Ohio.
6	ORTHO PHARMACEUTICAL CORPORATION, Linden, N.J.
7	THE OHIO CHEMICAL & MANUFACTURING COMPANY, Cleveland, Ohio.
8	THE ARMOUR LABORATORIES, Chicago, Ill.
9	C. B. FLEET COMPANY, INC., Lynchburg, Va.
10	THE MENNEN COMPANY, Newark, N.J.
11	BURROUGHS WELLCOME & COMPANY, INC., New York, N.Y.
12	MUTUAL MEDICAL INSURANCE, INC., Indianapolis, Ind.
13	REXAIR, INC., Detroit, Mich.
14	CHEMICO LABORATORIES, INC., Indianapolis, Ind.
15	MID-STATE PHARMACAL COMPANY, INC., Bedford, Ind.
16	H. G. FISCHER & COMPANY, Chicago, Ill.
18	THE COCA-COLA COMPANY, Atlanta, Georgia.
19	PAUL B. HOEBER, INC., New York, N.Y.
20	SPENCER, INC., New Haven, Conn.
21-22	THE MEDICAL PROTECTIVE COMPANY, Fort Wayne, Ind.
23	FREDERICK STEARNS & COMPANY DIVISION, Detroit, Mich.
24	J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.
25-26	CAMEL CIGARETTES, New York, N.Y.
27	WHITE LABORATORIES, INC., Newark, N.J.
28	GERBER PRODUCTS COMPANY, Fremont, Mich.
29	SCHERING CORPORATION, Bloomfield, N.J.
30	WILLIAM R. NIEDELSON, Detroit, Mich.
31	THE BAKER LABORATORIES, INC., Cleveland, Ohio.
32	VAN AUSDALL AND FARRAR, Indianapolis, Ind.
33	W. B. SAUNDERS COMPANY, Philadelphia, Pa.
34	ABBOTT LABORATORIES, North Chicago, Ill.
35	CIBA PHARMACEUTICAL PRODUCTS, INC., Summit, N.J.
36	THE C. V. MOSBY COMPANY, St. Louis, Mo.
37	PET MILK SALES CORPORATION, St. Louis, Mo.
38	C. B. KENDALL COMPANY, Indianapolis, Ind.
39	ELI LILLY AND COMPANY, Indianapolis, Ind.
40	E. R. SQUIBB & SONS, New York, N.Y.
41	CAMERON SURGICAL SPECIALTY COMPANY, Chicago, Ill.
42	M AND R DIETETIC LABORATORIES, INC., Columbus, Ohio.
43-44	PITMAN-MOORE COMPANY, Indianapolis, Ind.
45	PARKE, DAVIS & COMPANY, Detroit, Mich.
46	BRISTOL LABORATORIES, INC., New York, N.Y.
47	V. MUELLER & COMPANY, Chicago, Ill.
48	GENERAL ELECTRIC X-RAY CORPORATION, Chicago, Ill.
49	HOLLAND-RANTOS COMPANY, INC., New York, N.Y.
50	AKRON SURGICAL HOUSE, INC., Indianapolis, Ind.
51-52	PICKER X-RAY CORPORATION, New York, N.Y.
53	MEAD JOHINSON & COMPANY, Evansville, Ind.
54	AMERICAN HOSPITAL SUPPLY CORPORATION, Chicago, Ill.
55	LEDERLE LABORATORIES, INC., New York, N.Y.
56	THE DOHO CHEMICAL CORPORATION, New York, N.Y.
57	A. S. ALOE COMPANY, St. Louis, Mo.
58	PHILIP MORRIS & COMPANY, LTD., INC., New York, N.Y.
59	DAIRY COUNCILS OF INDIANA, Indianapolis, Ind.
60	D'ARCY'S, DY-PER SERVICE, Indianapolis, Ind.
61	H. J. HEINZ COMPANY, Pittsburgh, Pa.
62	MANHATTAN EYE SALVE COMPANY, INC., Louisville, Ky.
63	BECTON-DICKINSON & COMPANY, Rutherford, N.J.
65	MEIER ELECTRIC AND MACHINE CO., Indianapolis, Ind.
66	ST. PAUL MERCURY INDEMNITY COMPANY, St. Paul, Minn.
67	DEPUY MANUFACTURING COMPANY, Warsaw, Ind.
68	G. D. SEARLE & COMPANY, Chicago, Ill.
69	SHARP AND DOHME, INC., Philadelphia, Pa.
70	THE ALKALOL COMPANY, Taunton, Mass.
71	THE MAX WOCHER & SON COMPANY, Cincinnati, Ohio.
72	THE SMITH-DORSEY COMPANY, Lincoln, Nebr.
73	J. E. HANGER, INC., Indianapolis, Ind.
74-75	CURTIS AND FRENCH, Indianapolis, Ind.
76	THE DICK X-RAY COMPANY, INC., St. Louis, Mo.

Booth 1

SCHENLEY LABORATORIES, INC.

Executive Offices: New York City

The Schenley Laboratories' exhibit is devoted entirely to penicillin and penicillin products, and features clinical illustrations of treated patients. The complete apparatus for penicillin aerosol treatment of respiratory infections by inhalation is demonstrated to interested physicians by well-informed attendants at the booth. Descriptive literature concerning this treatment method and various Schenley Laboratories' products is supplied on request.

* * *

Booth 2

THE BORDEN COMPANY

New York City

Spend a few minutes with Borden at Booth 2—refresh your memory on our Prescription Products. Meet the new 13 fl. oz. Biolac, a concentrated liquid modified milk for infant feeding; New Improved Dryco with its high protein-low fat content for formula flexibility; Mull-Soy, liquid, emulsified soy food for your milk allergic patients; powdered whole milk, Klim, a dependable source of whole milk; the improved milk sugar Beta Lactose for carbohydrate supplementation; and the powdered Merrell-Soule Protein and Lactic Acid milks for special infant feeding cases.

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Booth 3

AMES COMPANY, INC.

Elkhart, Indiana

Demonstrating technics for the detection of urine-sugar, albumin, and occult blood.

Clinitest is a tablet method for the detection of urine-sugar. It is a copper-reduction test which develops its own heat within the test tube.

Albutest (Albumintest) is a reliable, nonpoisonous, noncorrosive tablet method for the detection of protein (albumin). It does not require heat.

Hematest is a new, unique, tablet method for the detection of occult blood in feces, urine, and other body fluids. It is a reliable procedure that can be carried out quickly by the physician, public health worker, or laboratory technician.

Booth 4

THE MALTINE COMPANY

New York City

The Maltine Company, New York (Booth 4), is exhibiting the old as well as the new. Such fine products as Maltine with Cod Liver Oil, Malto-Yerbine, and Neoferrum have enjoyed favorable recognition for many years. They have been joined by Tedral, Proloid, Depancol and other developments of The Maltine Company's research laboratories. A cordial invitation is extended to you to visit Booth 4, where descriptive literature and samples are available. Representative in charge, Mr. Owen W. Nichols.

* * *

Booth 5

THE PROCTOR & GAMBLE COMPANY

Ivorydale, Ohio

"Instructions for Bathing Your Baby," the third in Proctor & Gamble series of time-saving leaflet pads for doctors, is now available. Doctors may also re-order the first two pads in the series, "Instructions for Routine Care of Acne," and "Instructions for Bathing a Patient in Bed."

Additional leaflet pads are being prepared, designed to save doctors' time in answering patients' questions on routine home care.

* * *

Booth 6

ORTHO PHARMACEUTICAL CORPORATION

Linden, New Jersey

The Ortho Pharmaceutical Corporation will exhibit its complete line of gynecic pharmaceutical specialties. Featured will be their new product, Triple Sulfa Vaginal Cream specialty, designed for treatment of bacterial vaginitis.

Also displayed will be their complete line of materials for conception control featuring the new Ortho Sets.

They will be happy to have you visit booth 6. Samples and literature on all products will be available.

* * *

Booth 9

C. B. FLEET COMPANY, INC.

Lynchburg, Virginia

Phospho-Soda (Fleet). The Ethical Saline Eliminant.

Whot may you, as a physician, expect from this stable concentrate of the two U.S.P sodium phosphates?

1. Accurate dosage, regulated to the patient and to his condition.
2. The maximum therapeutic effectiveness of sodium phosphate.
3. Quick, gripeless evacuation for emergencies.
4. Mild, controllable elimination, for chronic biliary disturbonces ond constipation.
5. Unusual freedom from after-irritotion, with normalizing buffer action.
6. Safe action in the therapy of tropical diseases.

Are you getting the full value of medication in your daily problems of elimination?

* * *

Booth 10

THE MENNEN COMPANY

Newark, New Jersey

The Mennen Company will exhibit its two baby products—Mennen Baby Oil and Mennen Baby Powder-Borated, in addition to their fungicidal foot powder—Quinsana, their NEW prickly heat powder—Quicool, and Mennen Skin Balm.

Mennen Baby Oil—Antiseptic is now being used routinely by the majority of hospitals that are important in maternity work.

Booth 11

BURROUGHS WELLCOME & COMPANY, INC.

New York City

Burroughs Wellcome & Co. (U.S.A.), Inc., New York, cordially invite physicians to their exhibit of a representative group of fine pharmaceuticals and chemicals. Of particular interest are GLOBIN INSULIN, a new advance in diabetic control; DIGOXIN, a pure, stable, crystalline glycoside of Digitalis lanata, combining constant, uniform potency with rapidity of action; 'DEXIN' High Dextrin Carbohydrate, the milk modifier in which the non-fermentable portion predominates; and 'LUBAFAX' Brand Surgical Lubricant, one of our newest preparations.

* * *

Booth 12

MUTUAL MEDICAL INSURANCE, INC.

Indianapolis, Indiana

Details of Mutuol Medical Insurance, Inc., will be presented in an exhibit at the annual session.

This organization was established pursuant to a resolution of the House of Delegates of the Indiana State Medical Association. It was designed to operate as a companion plan to the Blue Cross Plan in providing a means for employed people to prepay the expense of surgical and medical service in hospitalized cases.

Mutual Medical Insurance, Inc., is an indemnity plan developed in accordance with the action of the House of Delegates. It provides a maximum of $150 for surgical procedures and a $3.00 indemnity for each day the doctor calls upon a member hospitalized for non-surgical or non-obstetrical cases. This daily payment is made for twenty-one days each year beginning with the fourth day of hospital confinement.

Like the hospital plan, the medical plan will be available only on a group basis. Literature may be obtained at Booth 12.

* * *

Booth 13

REXAIR, INC.

Detroit, Michigan

Rexair is a portable air cleaner that performs many hospital jobs. It purifies, deodorizes, and humidifies the air; cleans floors, walls and furniture; scrubs floors; draws in dust-laden air and sends out clean, moist air. Dirt is trapped in water, poured down drain. There is no bag to empty.

* * *

Booth 16

H. G. FISCHER & COMPANY

Chicago

Visitors to the Annual Session of the Indiana State Medical Association are cordially invited to visit our FISCHER Display Booth, to inspect the new units of FISCHER apparatus, and to inform themselves generally of the modern after-the-war trends in shockproof x-ray and electro-surgical-medical equipment. The FISCHER units of apparatus to be shown are characterized by new levels of precision design ond of convenient, efficient operation. In different words, they embody new standards of service to meet present-day professional demands. Members of the FISCHER organization will be present at all hours to answer questions and to demonstrate outstanding features of FISCHER design and performance. You will be welcome at Booth 16.

* * *

Booth 18

THE COCA-COLA COMPANY

Atlanta, Georgia

Coca-Cola will be served to the convention delegates and guests through the joint courtesy of the Coca-Cola Bottling Company, Indianapolis, and The Coca-Cola Company.

Booth 19

PAUL B. HOEBER, INC.

New York City

Now, more than ever, books—up-to-date, practical, and clinically orientated—are an indispensable part of the practicing doctor's armamentarium. At the Hoeber booth you will find a rich selection of the best in modern medical publishing, both in works for the general practitioner and the distiguished monographs for which this house is justly famous. Among the important new books on display will be Elman's "Parenteral Alimentation in Surgery," Mengert's "Postgraduate Obstetrics," Kardiner's "War Stress and Neurotic Illness," Nielsen's "Textbook of Clinical Neurology" (Ed. 2), and Cantor's "Ambulatory Proctology." Other distinguished recent publications include Saphir's "Autopsy Diagnosis and Technic," Nielsen's "Agnosia, Apraxia, Aphasia," MacKee and Cipollaro's "Skin Diseases in Children" (Ed. 2), Alvarez' classic "Nervousness, Indigestion, and Pain," and Schwedel's outstanding "Clinical Roentgenology of the Heart." These and many other books will well repay a leisurely visit to Booth 19.

* * *

Booth 20

SPENCER, INCORPORATED

New Haven, Connecticut

An interesting exhibit featuring Spencer Individually-Designed Supports for abdomen, back and breasts. Spencer Supports are prescribed as an aid to treatment for: hernia, visceroptosis with symptoms, spinal conditions, antepartum and postpartum, obesity, movable kidney, breast conditions, and other conditions where support therapy is indicated.

Samples are on display.

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Booths 21 and 22

THE MEDICAL PROTECTIVE COMPANY

Fort Wayne, Indiana

The Medical Protective Company is represented at Booths 21 and 22, where you are invited to call. Medical Protective Service is an institution of the medical profession, whose legal liability problems we have concentrated upon for forty-seven years.

Bring your professional liability questions and problems to Booths 21 and 22.

Our representative is at your service to present our protection plan, to explain the peculiar relation of the doctor to the law which governs your practice, or to discuss any particular phase of Professional Liability in which you are especially interested.

* * *

Booth 23

FREDERICK STEARNS & COMPANY DIVISION

Detroit, Michigan

You are cordially invited to visit the exhibit of Frederick Stearns & Company Division. Members of our professional staff will be in attendance to discuss these distinctive professional specialties developed in the Stearns Research Laboratories:

Neo-Synephrine Hydrochloride—sympathomimetic drug for intra-nasal, ophthalmic, and parenteral use.

Parenamine—a solution of amino acids, used in the prophylaxis and therapy of protein deficiency.

Adnephrin—for symptomatic relief of bronchial asthma.

Fergon—a better tolerated, better utilized iron salt; also, the Fairchild enzyme products now manufactured solely by Frederick Stearns & Company Division under the original Fairchild processes—Pepsencia, Gastron, and Holadin.

* * *

Booth 24

J. B. LIPPINCOTT COMPANY

Philadelphia

J. B. Lippincott Company, Philadelphia, Pennsylvania, presents a complete line of Lippincott Selected Medical Books and Journals.

Be sure to see the current issue of "American Practitioner"—a new medical journal designed to shorten the lag between experiment and practice.

New books and new editions include: TeLinde: "Operative Gynecology"; Guthrie: "History of Medicine"; Rosenthal, Stern and Rosenthal: "Diabetic Care in Pictures"; Berens and Zuckerman: "Diagnostic Examination of the Eye"; Bancroft and Murray: "Surgical Treatment of the Motor-Skeletal System"; Bancroft and Pilcher: "Surgical Treatment of the Soft Tissues"; Derbes and Engelhardt: "Treatment of Bronchial Asthma"; Pitkin's "Conduction Anesthesia," edited by Drs. Southworth and Hingson; and Lippincott's "Quick Reference Book," edited by Dr. Rehberger.

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Booths 25 and 26

CAMEL CIGARETTES

New York City

CAMEL Cigarettes will present a dramatic full-color review of their recent medical research on smoking, as well as the details of the nation-wide survey showing that "More Doctors Smoke Camels Than Any Other Cigarette." Another panel will illustrate the absorption of nicotine in the respiratory tract. Representatives will be present.

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Booth 27

WHITE LABORATORIES, INC.

Newark, New Jersey

White Laboratories, Inc., at Booth 27, present information regarding White's Sulfathiazole Gum—expressly formulated for topical chemotherapy in oropharyngeal infections; White's Otomide—a more effective means of topical chemotherapy in ear infections—and a NEW specialty, White's Mol-Iron Tablets, a new and definite advance in the treatment of iron deficiency anemias.

White's ethically-promoted vitamin specialties are also featured. You will find a very cordial welcome by White's Medical Service Representatives in charge of the exhibit.

* * *

Booth 28

GERBER PRODUCTS COMPANY

Fremont, Michigan

Come in and see us at Gerber's Baby Foods booth. Miss Harriet Davis, R.N., will be in attendance and will be glad to answer questions on Gerber's Baby Cereals, Gerber's Strained Foods, and Gerber's Chopped Foods.

Booklets are available on infant feeding as well as tested recipes for toddlers, and special adult diets. Professional Reference Cards give food values and chemical analyses of Gerber's Foods.

Samples of Gerber's new Strained Barley Cereal as well as Gerber's Cereal Food and Gerber's Strained Oatmeal are also available.

Remember, you are always welcome at the Gerber's Baby Foods booth.

* * *

Booth 29

SCHERING CORPORATION

Bloomfield, New Jersey

The Schering exhibit will feature the latest developments in endocrine therapy, radiographic aids, and other pharmaceutical advances.

Of particular interest is the presentation of Combisul-TD. Combisul-TD is a sulfonamide combination based upon the now-proved therapy which offers the therapeutic benefits of sulfathiazole and sulfadiazine with a material decrease in the danger of renal toxicity and crystalluria.

Schering professional service representatives will be present to answer inquiries and to provide valuable, informative literature.

Booth 30

WILLIAM R. NIEDELSON

Detroit, Michigan

The first showing of the newest cardiographic improvement in years, the CARDIOTRON, a direct-writing type, will be made at our exhibit. This instrument will eliminate photographic processes, batteries, and give permanent records.

Also on view will be the latest model Jones "MOTOR-BASAL," the original waterless B.M.R. unit.

* * *

Booth 31

THE BAKER LABORATORIES, INC.

Cleveland, Ohio

In the Baker exhibit you will see a line of infant foods that incorporates the newer trends and more recent thinking in infant nutrition. Both Baker's Modified Milk and Melcose are complete milk formulas, and completely prepared. Melodex (maltose and dextrin) is an economical carbohydrate in dry form, and is made especially for use in preparing evaporated or fresh milk formulas in the home.

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Booth 32

VAN AUSDALL & FARRAR

Indianapolis, Indiana

Ediphone Voicewriting Instruments, manufactured by Thomas A. Edison, Incorporated, will be presented by Van Ausdoll & Farrar, Indiana Distributors, with offices at Indianapolis, Evansville, and Fort Wayne. This exhibit will be featured by Edison's new postwar Electronic instruments, the Mercury and the Director. True fidelity voice recording, so important for the use of medical terms, now becomes available to the physician and surgeon. Mr. C. F. Farrar and Mr. L. E. Grisso will be on hand in Exhibit 32 to demonstrate these instruments to you.

* * *

Booth 33

W. B. SAUNDERS COMPANY

Philadelphia, Pennsylvania

This publishing house will exhibit its complete line of books, including Hyman's four-volume "Integrated Practice of Medicine"; Bockus, 3-volume work on "Gastro-enterology"; new (5th) edition of Beckman's "Treatment"; Allen, Borker & Hines' "Peripheral Vascular Diseases"; new (2nd) edition of Mason's "Preoperative and Postoperative Care"; new (2nd) edition of Graybiel & White's "Electrocardiography"; new (3rd) edition of Andrews' "Disease of the Skin"; Cooke's "Allergy"; Russell's "Malariology"; new (5th) edition of Curtis' "Gynecology"; Jackson & Jackson's "Diseases of the Nose, Throat and Ear"; new (4th) edition of Mitchell & Nelson's "Pediatrics," and many others.

* * *

Booth 34

ABBOTT LABORATORIES

North Chicago, Illinois

You are most cordially invited to visit the exhibit prepared for this meeting. Members of the Abbott professional service staff will be present and will welcome an opportunity to discuss newer developments in the antibiotic, anticonvulsant, anesthetic, allergenic, sulfonamide, hematinic, hormone, vitamin, and other fields.

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Booth 35

CIBA PHARMACEUTICAL PRODUCTS, INC.

Summit, New Jersey

Ciba invites all physicians to visit its display at Booth 35. Among the many products exhibited will be PYRIBENZAMINE, Ciba's new antihistaminic compound for the relief of allergies; PRIVINE HCl, a potent nasal vasoconstrictor with prolonged action which has gained recognition in its field; METANDREN Linguets, the most potent orally active androgen available in suitable form for sublingual use; TRASENTINE, a well-tolerated antispasmodic with ability to abolish spasticities of the hollow abdominal viscera; and TRASENTINE-PHENOBARBITAL, a combination of the potent antispasmodic TRASENTINE and the well-known sedative, Phenobarbital..

For samples and literature on all products of Ciba manufacture, see our representative in attendance, who will be glad to answer your questions.

* * *

Booth 36

THE C. V. MOSBY COMPANY

St. Louis, Missouri

New books and new editions to be displayed by the C. V. Mosby Company will include Polyak's "The Humon Ear in Anatomical Transparencies"; Clendening-Hashinger's "Methods of Diagnosis"; Rubin's "Uterotubal Insufflation"; Key-Conwell's "Fractures, Dislocations and Sprains"; Tassman's "Eye Manifestations of Internal Diseases"; Bonyai's "Pneumoperitoneum Treatment"; Thewlis's "Care of the Aged"; John's "Diabetes"; Anderson's "Synopsis of Pathology"; and Main's "Synopsis of Physiology." A cordial invitation is extended to examine these, as well as any of the many other books of timely interest which will be on display at Booth 36.

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Booth 37

PET MILK SALES CORPORATION

St. Louis, Missouri

A complete display of material illustroting the time-saving Pet Milk services available to physicians. Specially-trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

* * *

Booth 38

THE ARMOUR LABORATORIES

Chicago, Illinois

Members of The Indiono State Medical Association cordially are invited to visit the Armour display in Booth 8. Physicians moy on request receive the new Armour book, "Function and Malfunction of the Biliary System."

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Booth 39

ELI LILLY AND COMPANY

Indianapolis, Indiana

The Lilly exhibit will feature an interesting demonstration in miniature on penicillin culture. Many Lilly products will be on display, and attending Lilly medical service representotives will be present to assist visiting physicians in every possible way.

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Booth 40

E. R. SQUIBB & SONS

New York City

E. R. Squibb & Sons will have an exhibit showing the blood levels produced by Penicillin when administered in either Oil and Wox or in aqueous solution. Dosages for a variety of diseases also will be shown.

* * *

Booth 41

CAMERON SURGICAL SPECIALTY COMPANY

Chicago, Illinois

See the new Cameron Electro-Surgical Units, Coagulair-Sigmoidoscope, Electro-Diagnostosets, Flexible Gastroscopes, Bronchoscopes-Esophagoscopes-Laryngoscopes, Mirrolite, Binocular Spectacle Loupe, Magniscope, and other specialties developed for your postwar diagnosis, treatment and surgery, in Booth 41. All products available for prompt delivery.

Booth 42

M & R DIETETIC LABORATORIES, INC.

Columbus, Ohio

M & R Dietetic Laboratories, Inc., Booth 42, will display Similac, a food for infants deprived either partially or entirely of breast milk. Messrs. R. E. Davis and A. O. Caldwell will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

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Booths 43 and 44

PITMAN-MOORE COMPANY

Indianapolis, Indiana

Recent advances in pharmaceutical and biological chemistry will be featured at the Pitman-Moore display, Booths 43 and 44. The biologics will include the new and more antigenic Rabies Vaccine, Ultraviolet Irradiation Killed; Influenza Virus Vaccine; and Typhus Vaccine. Pharmaceutical products include a new topical application combining sulfathiazole and tyrothricin, new products for the oral administration of sulfonamides, and other recent advances from the Pitman-Moore research laboratories.

Members of the Pitman-Moore medical service department will be on hand to greet their friends in the profession, and members of the scientific staff will be present to explain recent scientific developments and answer technical questions concerning the Company's products.

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Booth 45

PARKE, DAVIS & COMPANY

Detroit, Michigan

Representatives of Parke, Davis & Co., well informed concerning progress in Pharmaceutical Research, and desirous of presenting new advancements to you, will be in attendance at our Technical Exhibit to discuss the nature and employment of new and present products. Displayed will be such outstanding products as THEELIN, MAPHARSEN, and ADRENALIN PREPARATIONS. The latest type of BIOLOGICALS will be on display. Likewise, PENICILLIN and other therapeutic agents of antibiotic, biological, and chemotherapeutic interest will be shown. We sincerely invite your visit to this Exhibit.

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Booth 46

BRISTOL LABORATORIES, INC.

New York City

The keynote of the Bristol Laboratories' display at the Indiana State Medical Association convention is a set of "before" and "after" photographs of case histories of penicillin therapy in 8"x10" full-color transparencies. Package material of penicillin and other parenterals are also on display.

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Booth 47

V. MUELLER & COMPANY

Chicago, Illinois

V. Mueller & Company will present some new surgical developments as a part of their exhibit of Mueller quality instruments. Also, the New Liebel-Flarsheim Short Wave will be on display. Their Indiana representative, Mr. Fred Hagan, will be in charge of their exhibit.

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Booth 48

GENERAL ELECTRIC X-RAY CORPORATION

Chicago, Illinois

Factual discussions with members of our Indianapolis sales and service organization during the state meeting will aid you in your future appa atus planning. If you are thinking about new and improved x-ray or electromedical apparatus, our layout engineers can help you with detailed plans and specifications.

Possibly an improvement in radiographic end results is indicated. Or you may wish to know how G-E's Periodic Inspection and Adjustment Service can help keep your equipment at its maximum operating efficiency. Why not drop in and avail yourself of our wide experience and know-how.

We will demonstrate the BERMAN METAL LOCATOR, a scientific device for the location of metallic foreign bodies embedded in tissues. The BERMAN METAL LOCATOR provides both visual and audible indications to guide the surgeon in locating the foreign body. It is accurate, efficient, and portable.

* * *

Booth 49

HOLLAND-RANTOS COMPANY, INC.

New York Los Angeles Chicago

You are cordially invited to visit the Holland-Rantos booth, where on display will be the nationally-known and universally-used Koromex contraceptive specialties. Besides the new Koromex Set Complete, which is a package combining the necessary items for complete contraceptive technique, will be the new Nylmerate Jelly introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of a non-specific origin.

Representatives of the company will be on hand to answer all questions. Samples of Nylmerate Jelly and Koromex Jelly will be available, as will copies of the Dickinson-Freret Chart.

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Booth 50

AKRON SURGICAL HOUSE, INC.

Indianapolis, Indiana

The Akron Surgical House, Inc., exhibit will feature Stille imported rustless steel instruments and the Master domestic line in both rustless and chrome instruments. Also will be shown a representative line of Hamilton office furniture.

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Booth 53

MEAD JOHNSON & COMPANY

Evansville, Indiana

Servamus Fidem means "We Are Keeping the Faith." Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum, and other infant diet materials—including the new pre-cooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booth 53 will be time well spent.

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Booth 54

AMERICAN HOSPITAL SUPPLY CORPORATION

Chicago, Illinois

Baxter Intravenous Solutions and Equipment for collection and transfusion of whole blood will be a feature of the booth of the American Hospital Supply Corporation. In addition, Plasma and Serum preparation and infusion equipment will be on display. Solutions in the famous Baxter Vacoliters will be shown, along with such transfusion equipment as Transfuso-Vacs, Plasma Vacs, and Centri-Vacs. A trained staff will be in attendance to explain the newest in equipment and to answer questions on all phases of the Baxter Intravenous Technique.

Also on display will be many specialty items of importance to better hospital routine and service.

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Booth 55

LEDERLE LABORATORIES DIVISION AMERICAN CYANAMID CO.

New York City

Lederle Laboratories will exhibit Penicillin, Sulfonamides, Biologicals, Allergenic Products and Pharmaceuticals, featuring Folvite (Folic Acid), the most powerful form of the vitamin yet discovered, which is identical with natural folic acid (L. casei factor) as originally isolated from liver. Folvite Lederle

has been found effective in the treatment of the macrocytic anemias of sprue, pregnancy, pellagra, and infancy. It has been found to produce remission of Addisonian pernicious anemia in relapse or when previously untreated.

In attendance will be N. L. Donelson, R. F. Brookshire, H. W. Kivett, S. Denham, Jr., and P. L. Greene.

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Booth 57

A. S. ALOE COMPANY

St. Louis, Missouri

Representatives of the A. S. Aloe Company will be happy to meet their friends from Indiana in Booth 57. They have on display a cross section of the Medical, Laboratory and Physio-Therapy equipment distributed by the world's largest surgical supply house. In addition to many other items worthy of note, a selection of government surplus items will be featured. These instruments are all new and fully certified. They are, moreover, available for immediate delivery, and the fact that they are selling at surplus prices makes them doubly attractive. By all means, drop by Booth 57 and ask to see the government specials.

* * *

Booth 58

PHILIP MORRIS & COMPANY, LTD., INC.

New York

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

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Booth 59

DAIRY COUNCILS OF INDIANA

The Dairy Councils of Indiana will feature an exhibit which shows that "Food Makes a Difference." You are cordially invited to stop at this booth for a cold, refreshing bottle of milk while you examine our attractive health education materials.

The exhibit is sponsored by the Dairy Councils of Elkhart, Evansville, Fort Wayne, Indianapolis, Kokomo, and South Bend. These units are affiliated with the National Dairy Council of Chicago, Illinois, which is the health educational organization of the dairy industry. The services of the Dairy Councils and their materials are free of charge.

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Booth 60

D'ARCY'S, AND DY-PER SERVICE

Indianapolis, Indiana

A cordial invitation is extended to all attending physicians to visit D'Arcy's booth where children's clothing needs from the cradle to twelve years of age and maternity wear will be displayed. Layette lists will be supplied physicians upon request. Dy-Per Service, Inc., a specialized, scientific laundry service, and D'Arcy's lending library on child training and psychology also will be featured in the exhibit. Register for your copy of BABY TALK, a monthly magazine, which will be mailed to you regularly at no charge.

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Booth 61

H. J. HEINZ COMPANY

Pittsburgh, Pennsylvania

H. J. Heinz Company is displaying and sampling their Strained Foods for infants, and Junior Foods, especially designed for intermediate feeding. When their representatives acquaint you with the infinite care involved in bringing these foods from the field to the market in tins, you will agree that Heinz Baby Foods merit your recommendation.

They are presenting a new publication, "The Nutritive Value of Vegetables." Examine, then register for it. A reminder—if desired, also register for the 11th edition "Nutritional Chart, Nutritional Observatory."

Booth 62

MANHATTAN EYE SALVE COMPANY

Louisville, Kentucky

The practice of supplying Ophthalmic Ointments for the exclusive use of oculists and physicians, put up in pointed tip tubes of pure block tin, was originated by this company in 1900.

Since that time we have devoted our entire attention to this one line of manufacture, and we feel that we are in better position to serve you than companies manufacturing varied lines of drugs and chemicals.

All ointments bearing the M.E.S. label are guaranteed to conform to Federal laws and A.M.A. rules governing standards and purity of this type product.

We also wish to introduce our affiliated MANHATTAN PHARMACAL CO.

This organization, separate and distinct from MANHATTAN EYE SALVE CO., manufactures and distributes a complete line of ethical, quality pharmaceuticals for the medical profession only.

MANHATTAN PHARMACAL CO. will feature Amosate (Amino Acids) and Benzylan, an improved Benzyl Benzoate Emulsion. We will be glad to discuss these products with you.

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Booth 63

BECTON, DICKINSON & COMPANY

Rutherford, N.J.

Becton, Dickinson & Company will exhibit in its booth the usual lines of syringes, needles, Ace Bandages, and diagnostic instruments, but will feature the new B-D Vacutainer and the Vacutainer method of taking bloods. Experienced technicians will be available at all times to demonstrate this time-saving method of blood-taking, as well as the complete line of blood-taking tubes.

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Booth 65

MEIER ELECTRIC & MACHINE COMPANY

Indianapolis, Indiana

"Filtered Air through FILT-R-FAN" is featured in the exhibit of the Meier Electric & Machine Company. The FILT-R-FAN is bringing relief and comfort to many who suffer from respiratory conditions. You are cordially invited to stop in Booth 65 and see our display. A FILT-R-FAN will be in operation and a representative will be glad to answer your questions.

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Booth 66

SAINT PAUL-MERCURY INDEMNITY COMPANY

Saint Paul, Minnesota Indianapolis, Indiana

The Indiana State Medical Association announced a Group Malpractice Insurance Program, written through local agents of the Saint Paul-Mercury Indemnity Company, to its members approximately two years ago.

The need for such insurance is as important today as it was then. During the October medical association meeting in Indianapolis, we will maintain Booth 66 for the purpose of supplying information regarding the plan.

The program which has been instituted for Indiana is both preventative and remedial. It aims to reduce accidents and causes for damage suits, as well as provide better protection to the individual members of the association.

The company is committed to work very closely with your legal counsel, Mr. Albert Stump. By this method it will enable physicians as a group to withstand the onslaught of racketeers who willingly and knowingly accept such cases for the purpose of avoiding legitimate hospital and medical expenses.

We will welcome your criticisms and your suggestions. How can we make the Indiana plan a model for other states to follow?

Booth 67

DEPUY MANUFACTURING COMPANY

Warsaw, Indiana

DePuy will exhibit in Baath 67 Madern Fracture Appliances, such as the new DePuy Bone Drill withaut any trambane guide and the new Can't-Drap screw driver. In ather wards, we have develaped a screw driver where yau cannat drap a bane screw with it. This means a lat ta the surgean in nat delaying sterilizatian, which means hastening the aperatian. All the latest fracture appliances will be an display, and we shall be glad ta have yau cantact us far yaur canstructive criticism Mr. Charles F Klingel will be in charge af the baath and will extend every caurtesy ta yau.

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Booth 68

G. D. SEARLE & CO.

Chicago, Illinois

Yau are cardially invited ta visit the Searle baath, where representatives will be happy ta answer questians pertaining to Searle Praducts af Research. Featured will be Searle Aminaphyllin, Metamucil, Ketachal, Flaraquin, Diadaquin, Pavatrine, Tetrathiane, and Ganadaphysin.

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Booth 69

SHARP & DOHME, INC.

Philadelphia, Pennsylvania

Sharp & Dahme will have their display at Baath 69, featuring "Sulfathalidine," "Sulfasuxidine," Tyrathricin Concentrate far human use, "Prathricin" antibiatic nasal decangestant cantaining tyrathricin and "Prapadrine" Hydrachlaride, "Tyraderm" Tyrathricin Cream, and "Lyavac" Narmal Human Plasma. A cardial welcame awaits all visitars.

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Booth 70

THE ALKALOL COMPANY

Taunton, Massachusetts

The Alkalal Campany is this year completing fifty years af service ta the medical prafessian. The campany manufactures twa famaus preparatians: (1) Alkalal—a scientifically balanced alkaline, saline salutian cantaining na glycerine and barely a trace af alcahal. It is hypatanic and a mucus salvent, and (2) Irrigal—an alkaline, saline dauche powder which makes a nantaxic, slightly astringent salutian, useful as a vaginal dauche, rectal enema, and far calanic irrigatians.

Representatives: Carrall L. Bristol and Flayd L. Crass.

* * *

Booth 71

THE MAX WOCHER & SON COMPANY

Cincinnati, Ohio

Indiana physicians have discavered the advantages af dealing direct with a manufacturer of surgical and medical instruments and furniture. The Max Wacher and Son Co., af Cincinnati, has its awn representatives thraughaut the state and considers the annual meetings ane af its best mediums far presenting its praducts. The Wacher exhibit will shaw many af the instruments that have reappeared an the market since the war's end. It will alsa present the newest madels in treatment furniture direct fram its factories at Cincinnati. Treatment tables, cabinets, stands, and accessaries are the finest examples of metal-cabinet making. An examinatian of this new line will canvince even the mast skeptical physician that his treatment raam can be completely madernized at extremely maderate cast.

Be sure ta see the Wacher "Whirlwind" Pump. It's a quiet little giant that gives the physician all the advantages af abundant campressed air and suctian anywhere that it can be plugged in.

* * *

Booth 72

THE SMITH-DORSEY COMPANY

Lincoln, Nebraska

The Smith-Darsey exhibit will feature Estragenic Substances and the representatives will be happy ta answer any and all questians cancerning this praduct. Other injectable preparatians will alsa be displayed, and representatives fram the hame labarataries, as well as Indiana medical service representatives, will be present.

* * *

Booth 73

J. E. HANGER, INC.

Indianapolis, Indiana

J. E. Hanger, Inc., manufacturers af artificial legs and arms, invite aur friends af the Indiana State Medical Assaciatian ta visit aur exhibit in Baath 73, where we have an display aur praducts shawing numeraus impravements which have been made in artificial limbs, such as impraved BK jaints, hip jaints, and the new and impraved hip jaint far tilting table legs, as well as samples af laminated parts in raugh, praved by gavernment tests ta be stranger than salid structures. Such acquirements are the result af eighty-five years af experience during which time we have enjayed the splendid caaperatian af the medical prafessian.

Attended by J. G. Best and Stanley E. Hedges.

* * *

Booths 74 and 75

CURTIS AND FRENCH

Indianapolis, Indiana

Curtis and French, 510 Narth Capital Avenue, Indianapalis 4, Indiana, will have several pieces af new equipment an display far your inspectian during the annual sessian af the Indiana State Medical Assaciatian. Jack Curtis, "Mac" McCain and Ed Clark will be in the baath ta assist yau.

* * *

Booth 76

THE DICK X-RAY COMPANY

St. Louis, Missouri

The Dick X-Ray Campany will have an display: Westinghause X-Ray Equipment—Liebel-Flarsheim Shart Wave Machines—Cambridge "Simpli-tral" Partable Electrocardiagraph —Fluarescent Viewers.

For information concerning recent developments in pharmaceutical and biological chemistry and other allied fields of importance to the physician, visit the booths of these commercial exhibitors and learn what they have to offer.

THE JOURNAL
OF THE
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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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Editorials

THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

GENERAL PRACTICE

Since the dawn of creation man's struggle to survive has been continuously entwined with the activities of the practitioner of healing. Illness has been a major component of his personality, and disease has run the gamut of life with him. The evolution from the weird rituals of our early ancestors through the centuries to the present highly scientific employment of laboratory measures, surgery, and chemotherapy is a chronicle of medicine's inexorable progress in the elimination of disease and the preservation of life. Consequently the role of the doctor of medicine in the life and health of all people has been, is, and will continue to be of unequalled importance.

Until a few short years ago the general practitioner was pre-eminent in the field of medical care, but with the developments in surgery and the specialties there has arisen the tendency to decry his accomplishments and to limit his activities. We are told that he is a relic of the horse-and-buggy days, an excellent topic for sentimental journalistic reflection, but, withal, a man who knows less and less about more and more and is ready to be consigned, with other antiquities, to the limbo of useless necessities. Yet he continues, and will continue, to do the greater part of all medical work, and while the social order may change his name, the same work will remain to be done and the same men will do it.

It is with genuine pleasure, therefore, that we find this issue of THE JOURNAL dedicated to the "General Practice of Medicine." Following the lead of several state medical associations, including our own, in establishing sections for the General Practice of Medicine, the House of Delegates of the American Medical Association gave similar endorsement at the San Francisco meeting. This seemingly belated recognition is of importance for many reasons, not only because of the fact that from 70 to 75 per cent of all medical practitioners are engaged in general practice, but principally because of the definite conviction that 80 to 85 per cent of patients can be skillfully and successfully treated by a well-trained general practitioner. It further indicates the belief, on the part of the doctor of medicine, that something definite must be done to combat the trend toward the concept that only specialists are qualified to treat patients.

Admitting the evidence that medicine has made such great strides in recent years that no one

individual can possibly master all there is to know, there still remains the indisputable fact that in the parade of patients through the general practitioner's office come the signs and symptoms of many and varied conditions—general medical, surgical, obstetrical, gynecological, pediatric, and psychosomatic, and from that broad experience must come the preponderance of skillful medical care. Here are seen the emergencies of life; here is the responsibility for the recognition of diabetic coma, uremic convulsions, coronary accidents, eclampsia, and cerebral episodes; here are met the mounting toll of accidental injuries; here come the emergencies of intestinal obstruction, appendicitis, perforated peptic ulcers, ectopic pregnancy, placenta praevia, strangulated hernia, and many others. Contagious diseases, arthritis, neuritis, diabetes, venereal diseases, psychiatric problems, and the early recognition of the three great killers, cancer, tuberculosis, and cardiovascular renal disease all cross the doorstep of the man in general practice. He must be, and in most instances is, capable of treating them or in directing them to proper sources of good medical care. His role in preventive medicine must be maintained through the proper application of immunization, and he must continue his activity as a leader in community welfare. His, continues to be a life of service to bring relief from disease and to bring hope to the cheerless and courage to the weak.

The difficulties of modern practice are not essentially different from those of fifty years ago. The same qualities of sympathy, integrity, kindness, personal interest, cheerfulness, and hope are required today. Only the degree of learning has changed; the requirements are more exacting. Half a century ago a working knowledge of all the departments of medicine was attainable. Today that has become impossible. Not only does modern surgery and applied medicine demand an unusual knowledge, but it also requires expert skill and judgment in the handling of instruments and remedial agents, and in the interpretation of laboratory findings. But not all this can discount the value of the general practitioner, nor displace him from the eminent position he has gained through character, a capacity for hard work, knowledge of medical science, and the ability properly to apply this knowledge in the recognition and treatment of disease. Far greater preparation in education, experience, and higher standards of character are required to fit a medical man for general practice than for any specialized field of practice. Specialization tends to destroy personal service and personal interest. The intangibles of medical practice are, too often, found lacking in the cold atmosphere of specialized case treatment.

Today there are about eight general practitioners to every specialist, and yet we are witnessing the paradoxical situation of seeing hospital and teaching appointments refused to men in general practice. The recognition of certified specialists by the governmental agencies does not bode well for the general man should compulsory health insurance find acceptance. The relief from such situations must become apparent. The new sections on general practice should see that abusive measures regarding hospital and teaching appointments are corrected. There should evolve a great and forceful national organization devoted to the problems and welfare of the general practice of medicine and dedicated to the improvement and standardization of training in general practice. Indiana has already set up its own Board of Certification in the General Practice of Medicine, and its success requires the active interest and support of all men so engaged. A national board for such certification must develop soon if the doctor of general medicine is to maintain his proper position equal to that assumed by diplomates of specialty boards. At present there is no legal basis for determining who shall be considered competent to practice a specialty. But there is a distinct practical basis, and it is in operation. General practitioners should recognize this fact and meet it through their own progressive efforts in organization and certification in their own field.

By this means we can foresee the development and recognition of competent practitioners who "with integrity of character, with ideals of medicine as a profession and not a trade, with a mind well stored with knowledge, with skill to apply this knowledge in a large proportion of cases of disease, with consciousness of his limitations, with readiness and ability to advise when and where expert help may be obtained, with good judgment and keen powers of observation sharpened by experience at the bedside and at the autopsy table are worthy to be the family doctor or adviser, with all the traditional privileges and rewards that came from the personal relation of the old-time doctor with the family—esteem and high standing in the community; the confidence and affection of his patients."

OUR PRESIDENT

Back in 1880, near the little hamlet of Eden, Hancock County, Indiana, Jesse Egbert Ferrell was born. This was some nine miles from Greenfield, the county seat, and the former home of James Whitcomb Riley. His parents were farmer folk, and the younger Ferrell attended the country schools nearby for the full eight-year period.

His father died when Jesse was about thirteen, and three years later his mother passed away. There were no other children. The old family doctor, William A. Justice, then practicing in Eden, gave young Ferrell a home from that time on. In the meantime, he had graduated from high school, had attended summer school and decided on teaching as a profession. This summer school, by the way, was an institution in Indiana back in

those days. Some were called "Academies," while others assumed the name of "Normals."

His first teaching experience was in a "one-man-school" where a single teacher taught all grades, from the first to the eighth, sometimes quite a problem, especially if he had a few unruly grown-ups in his higher classes.

But the good old doctor finally persuaded Jesse to study medicine, so he entered the old Medical College of Indiana, graduating with the class of 1903. It is a coincidence that that same class had in its membership three future presidents of the Indiana State Medical Association, Doctors Crockett, Combs, and Ferrell.

He immediately returned to Eden, where he remained for twelve years, removing to Fortville, in the same county, where he has been located ever since. In 1908 he was married to Miss Bertha Newhart, of Fortville, and to this union were born two children, Virginia and Mars B. The latter is now in practice with his father, at Fortville, after spending three and one-half years in the Army Air Forces, as a flight surgeon.

Mrs. Ferrell died in 1935, and in 1941 Dr. Ferrell married Veneta Hunt.

It was a matter of but a short time until Dr. Ferrell became inoculated with the germ of organized medicine. A year after his graduation he attended the annual meeting, at West Baden, and from there on out he has been a confirmed association man. He was a member of the House of Delegates for twenty-five years, during that time becoming well grounded in organization affairs. His list of committee assignments, over the years, is a formidable one, due to the fact that it was early recognized that when an assignment was given him it was carried out. In this connection we are reminded of a remark made by the late Dr. Tom Oberlin, of Hammond. For many years Tom had been on this or that committee, most of whom carried on in a more or less perfunctory manner. Then came the day when he was named to a Reference Committee, with Ferrell as chairman. After the meeting Tom remarked to us, "That man Ferrell gave us a workout; for years I have been on committees and found little to do. But this year we held a meeting, then held another, and finally held a third. Ferrell wanted the report 'just so,' and we made it that way," which is typical of our outgoing president—half-way measures have no place in his doings; he wanted things "just so" and managed to have them that way.

Doctor Ferrell has had a big job, this past year, what with several special meetings of the House of Delegates and the Council, together with many extra committee sessions which he felt it necessary to attend. As we say, it has been a big job, but he has come through with all colors flying. He leaves his official connection with the Indiana State Medical Association with things in first-class order and with the thanks of every member for his indefatigable efforts.

So, again we enter upon our records the "well done; you have earned a respite from labors well performed."

ANNUAL REGISTRATION

At the 1945 session of the Indiana State Medical Association, held in Indianapolis, the House of Delegates voted in favor of an annual registration law, fixing the annual fee at two dollars and asking our legal counsel to prepare such a bill for introduction in the 1947 General Assembly.

The bill has been prepared and will be submitted to the Executive Committee and the Council for their consideration and such changes as may be suggested. As drawn, the bill is very brief and very much to the point. There should be little occasion for controversy as to its meaning. Since this is a direct action by the House of Delegates it is certain that some such measure will be presented for the consideration of the legislature. Opposition to such a measure is definitely less than it was a decade ago, when some of our members fought most valiantly against any such proposal. But as of today we believe that the very great majority of our membership is in favor of such a measure. We have come to believe that there is little hope that state treasury funds ever will be available to carry on the work we wish to have done, and as a matter of fact the campaigns against quackery and fraud that have been carried on in the past few years have been made at our own expense. Every so often there comes to light serious violations of the medical practice law, violations that could and would be curbed in a short time *if* our medical board had sufficient funds for a full-time investigator, which will be possible under the registration law.

As stated, the measure has been drawn up and will be acted on by our two bodies, the Council and the Executive Committee, after which THE JOURNAL will print the proposed measure, in full. In the meantime, be thinking it over, for in a few months the measure will be before our General Assembly.

THE "KAADT CLINIC" EXPOSÉ

Several years ago the *St. Louis Star* printed a series of articles exposing the "medical diploma mill" in that area. The reporter assigned to cover this story was able to obtain a medical diploma, plus a high school diploma, all in a period of a few weeks and at a "reasonable" cost. This exposé effectually closed the "mills," and they have not since reopened.

Some years later an up-and-at-'em reporter for the *Indianapolis News*, Walter Shead, obtained a chiropractic diploma from the notorious Briggs "school," in Indianapolis, in a matter of a very few

days. Shead did a "swell" job of it, borrowing this expression from our own Tommy Hendricks, to whom everything exceptionally well done is a "swell job." Of course, the Briggs outfit immediately folded up, and so far as Indiana is concerned he passed out of the picture.

Now comes Robert E. Johnson, of the *Indianapolis Star*, with a series of articles concerning the notorious "Kaadt Clinic," located in South Whitley, Indiana. Johnson planned his campaign just like the American Army planned theirs; before setting out, he knew just what to do and how to do it.

First he went to a well-known Indianapolis physician, a man eminently qualified in the subject of diabetes, for a complete physical examination. The report, which appears in one of Johnson's stories, shows the reporter to be in the best of health, with not a trace of diabetes. Nevertheless, when he reported at the Kaadt headquarters a bit later, he immediately was accepted as a diabetic patient and placed on the "treatment."

Now just a word as to the Kaadts: there are two of them—brothers, who formerly were located at Fort Wayne. There they became mixed up with the Federal Government, and after a trial, with conviction, they were granted a new trial, which never came up. Then they moved to South Whitley. One of the brothers is said to have retired, the other remaining on the job.

Johnson describes his entry into the office and his reception by an elderly woman in the uniform of a nurse. He did not see the doctor at that time, the nurse telling him what to do and arranging for his medicine. The *Star* printed a photograph of the array of medicine which was prescribed—several pills, et cetera, and a gallon bottle of what Johnson called vinegar and saltpeter. Like most new patients, he was impressed with the fact that the hospital table, where all patients get the "diabetic meals"—there are nine "basic" meals in the course of treatment, provided many food products taboo to all diabetics, including ice cream and cake.

Johnson says they do not test for sugar in the urine, only for diacetic acid. He relates that in one specimen he submitted he put in some shaving lotion, but got no comment from the nurse or the doctor on this. Bob Johnson writes entertainingly, and his comment proves that he is a close observer. He tells of conversations with other patients, and comments on the fact that *The Journal of the American Medical Association* had published the statement that of seventeen Pittsburgh people treated at South Whitley, thirteen developed diabetic coma when they returned home, and that five of them died.

The series is, as we say, well written and very much worth one's time in reading. To us of the medical profession it is an old, old story; we know quackery still thrives in Indiana, as well as elsewhere, and while we know the remedy, the means of its application has not been well established.

An editorial comment on the Johnson articles remarks that many folk take the stand that it is up to the medical profession to correct these evils, and at the same time gives its reason for not doing so. It is because of the cry of "persecution" raised by these quacks and fakers and, strange to say, a lot of people believe it is persecution.

Just where people get the notion that one of the jobs of being a doctor is to serve as "health police" is quite beyond us. Our notion is that it is the duty of the state to look after health affairs; the medical profession always has stood ready to render every possible assistance, but it certainly is not our job to do the police work and the prosecution.

The *Star* is to be complimented on this one-man crusade; that it will have a good effect cannot be doubted, but it is certain that after a short time the whole matter will have been forgotten and the gullibles will again flock to the Kaadts. That is, unless the action now pending before the State Medical Board, in which the revocation of the Kaadt license is sought, is successfully prosecuted.

Indiana is big enough to care for all her problems; she is big enough to care for this one in the proper manner, and by "proper manner" we mean the permanent closing of the alleged "clinic" and the revocation of the license of any medical man connected therewith.

MEDICAL PATRIARCH

Dr. Wilson T. Lawson, of Danville, celebrated his ninety-seventh birthday recently by attending to business as usual. That is to say, he went to his office that morning and went through the usual routine of a busy country doctor. He had been doing this for a good many years—sixty-eight, in fact, hence, saw no reason why merely another birthday should interfere with his regular routine.

A feature writer of the *Indianapolis Times* was sent to interview Doctor Lawson on this occasion, and has written a most interesting story about him and about his work.

Doctor Lawson graduated from the Miami Medical College in 1878, long before most of us were born, and immediately located in Danville. He tells of Doctor Lawson's first call, along in March of that year, when the temperature was not exactly conducive to personal comfort. He had not yet obtained a horse, and since this call necessitated a long trip into the country he borrowed the equipage of the local Presbyterian minister. He later became a "saddle-bag doctor," as were most medical men practicing in Indiana in those days. He delivered his first obstetrical case just sixty-eight years ago, and he is wondering if that man still is living. He has a record of fifteen hundred such cases, quite a number considering the fact that he has always been located in a country district.

It might be mentioned that a Logansport physician, Dr. J. B. Maxwell, thinking we might not see

the *Times* story, sent it to us. Dr. Maxwell, himself, might be termed somewhat of an "oldster"; he was born in 1859 and graduated from Rush Medical College in 1890.

In connection with the obstetrical work done by Doctor Lawson, it might be mentioned that since his ninetieth birthday he has not been active in that field, although he has made three deliveries since he reached that age.

He is the oldest living graduate of Wabash College, where he took his pre-medical work. The story is told of his college days, when he "stood guard" all night over a stone which had been placed on the campus, honoring President Hovey. It seems that some of the undergraduates plotted to remove this stone, whereupon Doctor Lawson, shotgun in hand, made his stand for the night, frustrating the plans of the plotters.

Doctor Lawson was an early addict to the motor car and, like many other doctors of the times, suffered a broken arm bone due to a kick-back in cranking the engine. He relates that this accident occurred in front of the local livery barn and that a neighboring veterinarian assisted in "setting the bone."

He has for a long time, been, and still is, secretary of the Hendricks County Medical Society—we have forgotten the exact number of years, but it is longer than anyone else has ever held such a position in Indiana. He also has been local health officer during all these years. He has been an indefatigable student of Indiana history, and in particular can he give full details of every important event that has transpired in his home county.

He likes to tell the story of the "theft" of the Ladoga Academy, when it was moved by wagon train, in the dead of night, to Danville, becoming the Central Normal College, more recently the Canterbury College.

He recalls several rather severe epidemics, particularly the wave of influenza, during World War I. He also recalls a cholera epidemic in the northern part of Hendricks County, many, many years ago.

One birthday custom of many years' standing was to mow his lawn on that day. This year, however, he had to forego that means of celebration, for he was "complaining" of his back.

Thus do we record the passing of many milestones by a practitioner of the "old school," a typical country doctor, a leader in his profession and in his community. We trust that we may again have the pleasure of meeting Doctor Lawson at the Indianapolis Convention, in October. Through the years he seldom has missed such a meeting.

This issue of THE JOURNAL is a digest of what goes on in Indiana Medicine—read it!

Editorial Notes

In a recent report from the Research Council for Economic Security it is stated that Indiana ranks only "fair" in public health; Ohio, Michigan, and Illinois rank "good"; while our sister state, Kentucky, is ranked as "poor." Illinois had an infant death rate of 35, Ohio and Michigan 41, Indiana 42, and Kentucky 53. Our enthusiasm for the new Board of Health setup and the new Health Council is so great that we are confident that in a short time a report from this body will show Indiana well up among the "good health leaders."

Members of the new Council for Mental Health have concluded a visit to all the state hospitals, where a complete investigation of every such institution was made—all members of the Council being present at each investigation. Their report shows that these institutions are in good order, well-maintained—in so far as this can be done with the limited help available, and that the inmates are well cared for. The report also compliments Governor Gates on his interest in health matters in general, particularly mental health. THE JOURNAL consistently has given the Governor a "pat on the back" for his attitude in matters of health, and we trust that at the next session of the General Assembly he will be able to have his health program endorsed to the very letter.

The Indianapolis Medical Society has sent a letter to every member of the Indiana State Medical Association, urging them to attend the big party, October 29, 30, and 31. They pledge a good time for everyone, including the ladies. The invitation carries with it a "key to the city," signed by the Mayor and the Chief of Police, along with a sticker to place on your windshield, stating that you are a visiting doctor; *ergo*, immune from the petty annoyances of not knowing just what the traffic rules may be.

It appears to one who has been attending these state meetings for more than four decades that this will be an outstanding meeting. The program is such that it will appeal to everyone, and the entertainment features are "tops."

The only rift in the matter is that of accommodations; Indianapolis hotels always are crowded and the take-a-chance convention attender may find himself put to it to find a lodging place; hence, we would again urge that reservations be arranged immediately. It seems that another organization, without consulting the Indianapolis Convention Bureau, has set its date for a convention immediately following ours; in fact, it overlaps by at least one day, which, of course, will complicate matters somewhat. However, those who have reservations for the full time of our convention need not be concerned about this.

In furtherance of the plan to cooperate in the opening of a Veterans Administration Hospital at Fort Benjamin Harrison, the Indianapolis Medical Society has named a Council of eight members who will have charge of the selection of consultants to the hospital. This Council is headed by Dr. Clyde G. Culbertson, and its personnel indicates that the group will carry on to the utmost satisfaction of all concerned. As announced in THE JOURNAL recently, Dr. John E. Kelly, of Dayton, Ohio. has been chosen as acting manager of the new institution, which is expected to open soon.

Miss Alberta Green, student nurse at the James Whitcomb Riley Hospital, Indianapolis, was slain while on duty in the institution recently, her assailant using a large club as the death-dealing weapon. A fellow student-nurse also was attacked by the killer, but is said to be recovering from her wounds. The murder has aroused Hoosier folk such as they never have been aroused. The invasion of one of the most famous of hospitals, even though guards are employed therein, and the murder of one of its nurses brings a universal demand that the slayer be apprehended and given the limit of punishment.

It is officially reported that there will be an increase of almost four million dollars in the federal allotment to Indiana for old age assistance, aid to dependent children, and aid to the blind, which will bring the total allotment to near nineteen million dollars for the next year. A staggering sum, yet if properly expended will represent money well placed. Society still owes a duty to dependents of all sorts, whether such dependency is the result of old age or physical disability, and if the alloted funds are used economically, and without too much overhead, there will be little complaint about it. Complaints now prevalent, and constantly increasing, are the vast administrative costs. It does seem that there could be a lopping off of some of the employes of these departments.

Comes now no little lay press comment on a statement said to be sponsored by some Eastern physicians, all of whom are recognized as leaders in their respective fields, that soon it will be possible to tell, beforehand, just about when folk who apparently are in the best of health will become ill. Much of this stems from a study of the medical records of more than twenty-thousand Army officers, over a period of some years. They aver that those who are overweight, plus a bit hypertensive, are headed for an illness later on. Talk about "cradle to the grave"; if this sort of thing keeps up it will not be long before the newborn babe, after sufficient study and laboratory checks, will be given a "health card" along about the time he begins to walk, telling him just what his future health will be.

Again our capital city has its troubles with "nursing homes," a misnomer if ever there was one. The most recent development resulted in the discovery of such a place where some of the occupants actually were chained to their beds and were most sadly neglected. An investigation was, of course, ordered and changes suggested for the laws regulating such places, but it is not believed that the remedy has been found. It is our opinion that the State Board of Health should be the supervisory agent of these places, and that regular inspections should be made of them. It has been noted that such places where they advertise the care of children are but a vaunt. On inspection the "home" was found inadequate and filthy to the highest degree; the children were poorly fed and poorly clad, with little or no cleanliness about them. Some of the millions referred to elsewhere in these columns might well be directed toward giving these kiddies better care than they have been receiving.

THE JOURNAL is deeply obligated to Dr. J. T. Oliphant and his committee for the "swell" job they have done in assembling and preparing the material for the special number on the General Practice of Medicine. So far as we know this is the second special number devoted to this subject by any of our state medical journals, North Carolina having published such a number several months ago.

The subject of the "General Practice as a Specialty" has for a number of years been thoroughly discussed, and in the last two or three years has been recognized as such by some of the state associations, as well as the American Medical Association.

"Jake" spent a lot of time in the preliminary consideration of this number, calling to his aid several men throughout the state. It might well be termed pioneer work, and as such opens the way for much of interest in years to come.

The general practitioner has but recently come into his own; for too many years he was considered the "family doctor"; too often it was forgotten that he is the "grass roots" of the entire medical profession. Now that he is to be considered as a "specialist" he will be accorded his just dues.

THE JOURNAL is inordinately proud of this number; it is an achievement. It represents a lot of planning, a lot of get-down-and-work, a lot of letter-writing, a lot of telephoning—a lot of other things; hence it is that THE JOURNAL extends heartiest gratitude to those who labored so long and earnestly in its production. We are certain that this number will be well received, not only in Indiana but in such other states where they are fortunate enough to peruse a copy.

President's Page

I take the liberty of quoting the Preamble to the Constitution of the United States, which is just as applicable today as it was when drafted in 1787. "We, the people of the United States, in order to form a more perfect Union, establish justice, insure domestic tranquillity, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America."

I believe that it is high time, considering the unrest that is prevalent in our country today, for every one of us to take stock of our activities and then ask ourselves: Have we formed a perfect Union; has justice been established; has domestic tranquillity been achieved; are we providing for the common defense and promoting the general welfare; and, above all, have we secured the blessings of liberty?

We all are proud of our form of Government; it is the best in the world today. We also know that there are subversive elements in our cosmopolitan population which would overthrow our form of Government should such forces gain sufficient control. Why should such conditions exist? Is it that we, who are born of democratic ideals, have put too much stress on individual freedom? Or is it that some foreign-born citizens take advantage of all opportunities, such opportunities often transpiring in surroundings where responsibility is at a very low ebb?

The Governor of Indiana has issued a proclamation that September seventeenth be designated as Constitution Day, and the Constitution Committee designated the week of September 15 to 21 as Constitution Week. I hope that every community in Indiana has celebrated this event appropriately, noting its meaning and its implication.

It is our high hope that the people of this great state and the nation realize just what the Constitution of the United States means—and the great sacrifices that have been made in lives and money to preserve our democratic way of life, as we know it—and that by mass action our citizens will make every attempt possible to see that these great losses shall never occur again. And the leaders of our nation must ever strive to keep before our people the ideals that are set forth in our Constitution.

We are prone to become rusty and complacent as to the real significance of our liberty, and I therefore firmly believe that the educational system of our country should stress the value of our form of Government and incorporate the teaching thereof in its curriculum; and that no student should graduate from high school without being able to recite the Preamble to the Constitution and the Constitution. In brief, it is the people's charter, and from its roots springs the greatness of our nation. It is our earnest prayer that the freedom stemming from these ideals shall never be cast aside; that posterity may enjoy our way of life—and may God grant that this freedom shall endure to the end of time.

J. E. Ferrell

GENERAL PRACTICE AS A SPECIALTY

JOHN M. PALM, M.D.

BRAZIL

General practice can be considered a "specialty." A "specialist" as we know him today is an individual who has an M.D. degree, and who has selected some specific part of medicine to which he will devote all of his time. Likewise, the physician who selects general practice as his specialty. He devotes all of his time to the practice of medicine, with limitations. Training, experience, and ability to pass certain standards which have been established by groups of men qualified in the specialty have netted him the right to be recognized as one who is highly trained and qualified to conduct his practice in the chosen branch.

The physician who selects general medicine can also qualify under these precepts. His practice will cover the field of medicine in all of its ramifications, in a general way, as differentiated from the detail study and training of a man who selects a single branch. The general practitioner must be as well trained in medicine as the specialist is in his limited part. The training, of course, will be as the name implies; in a general rather than in a detailed manner. Training standards can be established which when attained will qualify him to call himself a "specialist."

Let us compare the practice of medicine today with a wheel, with its component parts of hub, spokes, and rim. The field of detailed specialty may be considered the rim; the spokes the connecting pathways; and the hub the general practitioner.

The patient flow is through the axle to the hub, and thence through the spokes to the rim. Can we say which is most important? Without one component part the whole ceases to exist.

The general practitioner receives the patients at the hub, and, if necessary, directs them in the various pathways to the properly-trained physician for diagnosis. Economically, it is impossible for the average American to engage *specialists* to look after and care for his general medical needs. Much of the strife and turmoil American Medicine is in today can be laid at the feet of the men who have voluntarily set themselves up as specialists. There is argument as to whether the individuals who study and work with large numbers of certain types of diseases should not be better trained than those who see only a few, yet there is definite feeling that over-specialization has been adverse to the best interests of medicine. Hence, it seems essential that all men who work in the field of medicine must have passed certain standards of practice, so that they can be qualified as specialists. It is no longer sufficient to have a degree in medicine. The medical education system has become a huge octopus of knowledge, which extends its many arms into, through, and about the many ailments of mankind with therapeutic effect to his disease and disaster to his pocketbook.

Without the infantry an armed force would be helpless. True, atomic bombs can make a nation come to its knees in surrender, but the infantry must be there to receive the sword and to maintain and guard the peace. Can we say that the infantry is not a special arm? The highly-trained forces are of great aid, and can be and is the determining factor in many a battle, but the common foot soldier is, after all, the mainstay of the force. Similarly, the general practitioner—the "Infantryman of Medicine." It is his specialty to maintain and hold the ground which specialists have made available to him. The specialist must glean the knowledge from controlled research and detailed study and be ready to stand by the general practitioner to aid and assist him when necessary. It is the specialized training of the general practitioner which will make him realize his limitations and prompt him to call for assistance from the specific field wherein his patient's illness might lie. The medical schools have neglected this particular part of medicine.

It is, of course, necessary that medical students be taught by the most outstanding men in each of the various branches of medicine. However, they should also be shown that the whole of medicine is also a specialty.

In attempting to establish standards of training and qualifications for the General Practice of Medicine as a specialty, a board of qualified men should be selected by qualified general practitioners, with the aid and assistance of specifically-trained men. This board will then examine and pass upon men who have selected general practice as their specialty, and upon those who qualify it will place its stamp of approval.

It should be possible for a young medical man to receive training in all the various branches of medicine which would be equivalent to a Residency in Surgery, in Pediatrics, or in Obstetrics, as it is known today—a rotating residency that would be an extended rotating internship, except that in each service there would be sufficient time to study and learn to a greater degree. He would be directed in each of the branches by highly-trained men in the specific field, but his overall service would be controlled by a general practitioner. Many of the specialties are nothing more than manual dexterity in doing a certain thing; this, of course, separates the piano player from the artist, but in the case of the general practitioner his art lies in the handling of patients so that they may be exposed to the "manual dexterity."

If we analyze the general physician's practice, we find that most of them are qualified to do 85 per cent of the things that patients require in order to maintain their health. For example, he can diagnose and treat most of the eye, ear, nose, and throat conditions that are common to mankind. He, of course, will not attempt to do a submucous resection or a mastoid. He can shrink mucous membranes, treat otitis media, conjunctivitis, et cetera. He can treat bronchitis, pneumonia, tuberculosis, and other upper respiratory conditions. His knowledge of gastro-intestinal-tract pathology will allow him to care for many of these ailments. His greatest value is in being able to know the limitation of his knowledge and ability, and be ready to call for the specialist when he is needed.

The physician who can in one day see and care for cases of pernicious anemia, diabetes, hypertension, angina pectoris, gastric ulcer, cholangitis, nephritis, lues, obstetrics, climacteric (male and female), traumatic lesions, fractures, psoriasis, scabies, sinusitis, pneumonia, "flu," baby formulas and inoculations, the "old man's disease"—prostatitis —along with giving comfort to the individuals who have metastatic carcinoma, decompensated heart, the aged and weary cardiovascular renals, and who throws in a good smattering of measles, whooping cough, mumps, chickenpox, tonsilitis, appendicitis, balanitis, *ad infinitum*, can and must have a thorough training not only in the science of medicine, but in the all-important "Art of Medicine," which has been so sadly neglected in this day of super-scientific practice. This man is a "specialist." He is the "Specialist of the Art of Medicine," and should be so designated.

It is necessary that someone in the profession be free to care for the patient after the diagnosis and treatment has been outlined. The specialist of today cannot attend to all the little details incident to caring for the patient he has examined. If he did, he would no longer be a limited man and would not have the time that is required to maintain his knowledge, or to dispense it. Here is where the general practitioner comes into greatest usefulness. He will care for the carcinoma that is incurable, but which will require a great deal of sympathy, understanding care, and easing of pain before the grim day arrives. The man who aids nature in the process of birth, who treats the runny nose of childhood, the acne of adolescence, and eventually sees the cycle completed while caring for dad's heart and mamma's climacteric comes to know the individual a great deal deeper than the skin. He knows their sorrows, their cares, and their happiness without asking questions. This man becomes the great bulwark of the profession in that he keeps and maintains the true confidence of the people he cares for. Specialist? Yes, he is a specialist—a specialist in the Art of Medicine.

To maintain his gray cells in the fine fettle that is necessary to carry these responsibilities, he must regularly be in contact with the "specific field" men who will impart to him their gleaned knowledge in the advances of medical science. This can be done only by organized pedagogy; through seminars and short, intensive postgraduate work, where he not only listens but gets a chance to take part in individual reviews of subjects by various colleagues. In this way he can maintain his stand in the advancing tide of knowledge. It is hoped that in the near future such a plan and such a board will, and can, be evolved, so that the man who chooses the "Infantry of Medicine" can be given proper recognition in the Field of Medicine.

JOURNAL COVER PAGE

This issue of THE JOURNAL is dedicated to The General Practice of Medicine. The general practitioner is reluctant to talk about his own exploits, but there is one subject in which he is always enthusiastic—courage and devotion to duty in his mission of mercy. He has endured many dangers and hardships, and some of his heroism is portrayed in the reproduction used on the cover page, a painting by the late Wm. Mark Young, "Doctors of Five Eras," the illustration having been supplied through the courtesy of The Wm. S. Merrell Company.

Sir William Osler, in a comment in *Aequanimitas and Other Addresses XIV, Chauvinism in Medicine*, said: "A well-trained, sensible family doctor is one of the most valuable assets in a community, worth today, as in Homer's time, many another man. Few men live lives of more devoted self-sacrifice."

Again we quote from Osler, whose statement is as applicable today as it was when written forty-four years ago: "There never was a time in our history in which he was so much in evidence, in which he was so prosperous, in which his prospects were so good or his power in the community so potent. . . . He is the standard by which we are measured. What he is, we are; and the estimate of the profession in the eyes of the public is their estimate of him."

RESIDENCY IN GENERAL MEDICINE

HARRY E. KLEPINGER, M.D.

LAFAYETTE

The rapidity with which new advances in medicine are appearing, combined with an increasing desire on the part of the general public for better medical care, necessitates the development of a systematic program of postgraduate education. Included in this program should be residencies in the general practice of medicine.

The development of a residency (the term "residency" or "resident" in this article refers to a residency in general medicine) in many of our recognized hospitals would mean much to the future of the general practice of medicine, as well as to the entire medical profession. Staff members who are general practitioners, and who have the interest of the resident at heart, would add much to their own professional skill by their effort to teach the ideals of a family doctor. The specialists, with the assistance of general practitioners of the clinical staffs, would impart training of practical value to the resident, but would avoid lengthy discussions on rare and difficult diseases. This concerted effort of training would better enable the resident to recognize conditions that need special care, thereby correcting the most frequent complaint of the general practitioner—his hesitancy in recognizing conditions and making proper referral of cases needing the care of a specialist.

It is granted that a plan of general residency in one hospital may not be flexible enough to work in another hospital, but there are fundamentals that are applicable to all hospitals. The schedule should permit the resident to see patients in the various branches of medicine, and should be arranged so that he may gradually assume greater clinical responsibilities as his competence increases.

The schedule should cover the following services:

1. *General Medicine*—The requisite should include the treatment of acute and chronic illness encountered in office and bedside practice, with a fair understanding of cardiology, pediatrics, geriatrics, preventive medicine, and psychiatry. The general practitioner must have an intelligent and sympathetic attitude in order successfully to guide his patients and their families in health and disease.

2. *General Surgery*—This includes diagnosis, minor surgery, emergency surgery, and the various surgical specialties.

3. *Obstetrics and Gynecology*—This should include pre- and post-natal care and procedures of office gynecology.

4. *Out-Patient Service*—In addition to the above-mentioned services an arrangement should be made whereby some patients may be seen before and after, as well as during, their hospital stay. In some instances the resident could accompany a general practitioner on house calls as an observer.

5. *Anesthesia*—The resident should be qualified to give ether without supervision; and to administer nitrous oxide, spinal, and intravenous anesthesias under organized supervision.

6. *Clinical and Anatomical Pathology*—The resident should be able to perform routine laboratory tests on his patients, and should know normal values for blood chemistry and the proper methods and conditions under which specimens are obtained. This would enable him to evaluate laboratory procedures. He should be able to differentiate between normal and abnormal surgical specimens, and be able to describe a gross specimen adequately. He should be able to perform a necropsy under the direction of a pathologist.

7. *Clinical Physiology*—The resident should be able to recognize early abnormal physiological functions.

8. *Radiology*—The resident should have an assigned time at frequent intervals during which he can confer with a radiologist and thus become familiar with x-ray diagnosis.

The details of the educational content of any program may vary to meet the needs of different hospitals, but the following essentials are considered necessary:

1. History and Physical Examinations: If the service is not covered by an intern, the resident should secure an adequate history, perform a complete physical examination, and make a short mental status study. He then should record his tentative diagnosis by systems, which should be done before any laboratory work is undertaken.

2. Management of Patients: The intern should be responsible for the routine care of patients, but the resident should be responsible for the *type* of care administered.

3. Reporting of Referred Cases: In cases where the attending physician does not report his findings to the referring physician, the resident should write to him, informing him of the diagnosis and the therapy recommended.

4. Hospital Rounds: Rounds should be arranged by various staff men for a specific time each day.

5. Consultations: The resident should be present at all or most of the consultations.

6. Conferences: One hour should be devoted each week to conferences: pathological, physiological, psychiatrical, and Journal Club. Subjects such as medical economics, forensic medicine, hospital organization, and administration are valuable. At the Journal Club the resident should report on articles appearing in current journals of interest to the general practice of medicine, and should also report on assigned readings in basic sciences re-

lated to recent clinical problems encountered in the hospital.

7. Programs—Written Reports—Research: The resident should have some responsibility in developing programs for conferences. He should develop ability to organize facts and to write clearly. He should be trained to use the medical library, which must be adequate and which is a necessity to every hospital. A research problem should be encouraged, such as reviewing case reports from hospital records.

Occasionally a physician expresses the opinion that a residency can be successful only in a hospital where there are charity cases. This contention is not necessarily true. Private patients in hospitals where teaching facilities are available find that the quality of medical care is thereby greatly improved; they appreciate and often demand the extra attention and services made possible by a teaching residency.

The institution of residencies in qualified hospitals over the state, especially the smaller hospitals, is important in that the staffs then recognize that they have available in their own midst facilities for continuing their postgraduate education. This also promotes closer cooperation between the general practitioners and the specialists.

The residency can be educational and of considerable value to the resident as well as to the staff men who are general practitioners. The transition from an intern to a qualified general practitioner can be accomplished with much benefit to the profession in a hospital where a well-planned residency exists.

BY-LAWS
of
INDIANA BOARD OF GENERAL PRACTICE OF MEDICINE, INC.

Indiana is taking the lead in the development of a plan for the stimulation of interest in the general practice of medicine. This involves two methods: (1) awarding suitable honors to competent physicians in the field of general practice; (2) providing better facilities for postgraduate education to be made available to general practitioners. The ultimate objective of the plan is to provide better medical care to the patient.

After the authorizing resolution was adopted by the House of Delegates of the Indiana State Medical Association, on November 8, 1945, a committee of fifteen was appointed by Dr. N. K. Forster and continued by Dr. Jesse E. Ferrell. The members of this committee, acting as incorporators and the first Board of Directors, incorporated the "Indiana Board of General Practice of Medicine, Inc." The purpose of the board has been stated in former articles published in THE JOURNAL. We are now publishing the By-Laws for the information of all who are interested in this movement.

BY-LAWS

ARTICLE I

QUALIFICATION AND ELECTION OF MEMBERS

SECTION 1.—FOUNDER MEMBERS

The original membership of this organization shall be composed of not more than two hundred reputable physicians engaged in the general practice of medicine, who have been so engaged for at least ten years.

SECTION 2.—ADDITIONAL MEMBERS

Additional members shall be general practitioners of medicine who have passed the examination provided for in these By-Laws, and presented to the Board of Directors satisfactory proof of the following qualifications:

1. Membership in a local County Medical Society and citizenship of the United States.
2. High moral and ethical standing in the profession.
3. Graduation from a medical school recognized by the Council on Medical Education and Hospitals of the American Medical Association.
4. Completion of an approved interneship, preferably of the general rotating type, in a hospital approved by the same Council of the American Medical Association.
5. Continuance of post-graduate education.
6. A minimum of five years of general practice after completion of an approved interneship.

In special instances the Board may accept for examination outstanding candidates who were in practice prior to January 1, 1930, but whose formal training does not comply with the full preliminary requirements stated herein.

SECTION 3.—STEPS IN ACQUIRING MEMBERSHIP

The following steps shall be taken to acquire membership on this Board:

1. The applicant shall present his application on a form provided for that purpose.
2. A fee of $25.00 shall accompany the application.
3. The Committee on Qualifications shall ascertain whether the applicant possesses the qualifications stated in Section 2. If the Committee decides

that the applicant possesses the said qualifications it shall certify that fact to the Secretary, and the Secretary shall then include the name of the applicant in the list of those eligible to take the examination, which list he shall deliver to the Committee on Examinations.

4. The Committee on Examinations shall arrange for and conduct the examinations as indicated in these By-Laws. If the applicant passes the examination with grades satisfactory to said Committee, the Committee shall certify that fact to the Secretary. The President and Secretary shall thereupon execute a Certificate of Membership in which the applicant shall be awarded the honor of "Diplomate of the Indiana Board of General Practice of Medicine." The said document shall be delivered to the successful applicant at such time and place and under such circumstances and with such appropriate recognition of that event as may be determined by the Executive Committee.

SECTION 4.—DECISIONS OF COMMITTEES SHALL BE FINAL

All decisions of committees in connection with applications for membership shall be final, and no applicant shall have any right of appeal nor of any claim or action against the Board or any officer or Director thereof in event of his failure to pass any examination or because of the rejection of his application or his denial of membership on the Board, for any reason.

SECTION 5.—EXAMINATION OF APPLICANTS FOR MEMBERSHIP

The examinations in which all applicants shall be required to make a passing grade shall include:

Part I. A review of case reports.
Part II. A written clinical examination.
Part III. An oral clinical test.
Part IV. Demonstration of ability at bedside and in laboratory.

The following is an outline of matters to be included in each of these four parts:

Part I. The candidate must file twenty-five case reports, in condensed form, for which he was personally responsible. These case reports must be sufficiently complete to enable the examiners to evaluate the judgment of the candidate in his choice of procedure, and must include,

1. An account of the candidate's personal observation of the case.
2. The basis for diagnosis.
3. The facts which determined the course of treatment.
4. Critical conclusions to be drawn from the outcome of the case.

These case reports may cover a variety of material in one or more of the following fields: infectious diseases; deficiency diseases; diseases of metabolism; neoplastic diseases; diseases of the gastro-intestinal tract, respiratory system, kidneys, blood-forming organs, circulatory system, glands of internal secretion, nervous system, bones, joints, and muscles; obstetrics; pediatrics; dermatology; neuropsychiatry; office gynecology; surgery; and allergy.

Part II. The written examination will cover the basic medical sciences, and subjects pertaining to the general practice of medicine, having in view the determination of the question as to whether the applicant possesses the quality and extent of medical knowledge necessary for general practice of a high order.

Part III. The oral clinical test will be directed to the ascertainment of the candidate's familiarity with recent medical literature, the breadth of his clinical experience, his capabilities, general adaptability, comprehension and understanding of the patient's problems as a whole, and other qualifications requisite for highly competent general practice.

Part IV. Demonstration of ability at bedside and in laboratory will include the assignment of one or more patients in a hospital to the applicant so that his approach and procedure in handling a new patient may be observed by the Committee on Examinations.

Applicants who successfully complete one part of the examination may proceed to the next part in the order in which the parts are listed, until they have completed the entire examination. Whenever an applicant fails to pass the examination, or any part of it, the Committee on Examinations, upon request, will make suggestions as to suitable courses of instruction or other means of improvement through which the applicant may overcome any deficiencies causing such failure. Any applicant who fails to pass an examination, may, upon payment of an additional fee of $15.00, take another examination.

ARTICLE II

MEETINGS OF MEMBERS

SECTION 1.—ANNUAL MEETINGS

The annual meeting of the members shall be held prior to or during the time of, and at the place of, the annual convention of the Indiana State Medical Association, at a definite time to be fixed by the Executive Committee, for the election of Directors and the transaction of such other business as may come before the meeting. The Secretary shall cause notice of such meeting to be published in THE JOURNAL of the Indiana State Medical Association.

SECTION 2.—QUORUM

Twenty members attending a meeting, after due notice thereof published in THE JOURNAL, shall constitute a quorum.

SECTION 3.—ORGANIZATION AND ORDER OF BUSINESS

The President, and in his absence the Vice-President, and in the absence of both, any member chosen by the members present shall call the meeting to order and act as Chairman thereof. The Secretary of the Corporation shall act as Secretary of the meetings, but in his absence the presiding

officer may appoint any member to act as Secretary of the meeting.

The order of business shall be as follows:

1. Roll call.
2. Reading of minutes of preceding meeting, and action thereon.
3. Report of officers.
4. Report of committees.
5. Unfinished business.
6. Miscellaneous business.
7. New business.

ARTICLE III

BOARD OF DIRECTORS

SECTION 1.—NUMBER AND TERM OF OFFICE

The Board of Directors shall consist of fifteen members. The first Board of Directors shall divide themselves into three groups, by lot. The first group shall serve for a period of one year; the second, for a period of two years; and the third, for a period of three years. All Directors succeeding the members of the first Board of Directors shall be elected for a term of three years and until their successors are elected and qualified.

SECTION 2.—SELECTION OF DIRECTORS

The members of this Board in each Councilor District shall elect one of their members as a Director and report such election at the annual meeting. If the members of any District fail to elect a Director and report such election at the annual meeting, then the Director from such District failing to report shall be elected at the time of the annual meeting by the members from such District attending the annual meeting. A District meeting for the purpose of electing Directors shall be called by the Director from the District or by the District Councilor. The Faculty of the Indiana University School of Medicine will be requested to elect one Director, and the President of the State Medical Association will be requested to appoint a Director. Upon the failure of said Faculty or the President to make said appointments, the place, or places, of such Directors shall be filled by the election of a member, or members, for such place, or places, by the remaining Directors.

SECTION 3.—DUTIES

The affairs of this Corporation shall be managed by the Board of Directors. They shall employ such agents and servants and confer upon them such duties and powers as they deem advisable, and fix the rate of compensation for employees and officers, or make provision for the delegation of authority to fix wages for all employees except officers.

SECTION 4.—RESIGNATION AND REMOVAL

A Director may resign at any time by filing a written resignation with the Secretary. He may be removed for cause at any time in any meeting of the Directors called for that purpose by a majority vote of the Directors attending; or he may be removed at any meeting of the members, by a majority vote of the members attending, provided a quorum is present and notice of charges has been given to the Director, and to the members, at least twenty days before the meeting.

SECTION 5.—VACANCIES

Vacancies occurring in any manner may be filled by a majority vote of the remaining Directors electing a successor to fill such vacancy until the next annual meeting of the members, and until his successor is elected and qualified.

SECTION 6.—MEETINGS

Annual meetings of the Board of Directors shall be held immediately following the annual meeting of the members. Other meetings of the Board of Directors shall be held upon the call of the President or of one-third of the Directors. The Secretary shall give sufficient notice of meetings by mail or telegraph to enable the Directors to attend.

SECTION 7.—QUORUM

A majority of the Directors convened according to these By-Laws shall constitute a quorum for the transaction of business; but if at any meeting less than a quorum is present a majority of those present may adjourn the meeting from time to time without notice other than by announcement at the meeting until a majority shall attend.

SECTION 8.—ORGANIZATION AND ORDER OF BUSINESS

Organization and order of business shall be the same as in a meeting of the members, as above provided.

ARTICLE IV

GENERAL OFFICERS

SECTION 1.—OFFICERS AND THEIR ELECTION

The officers of this Corporation shall be the President, Vice-President, Secretary and Treasurer. They shall be members of the Board of Directors and shall be elected in the annual meeting of the Board immediately following the annual meeting of the members. The offices of Secretary and of Treasurer may be held by the same person.

SECTION 2.—DUTIES OF OFFICERS

The principal duties of the general officers, respectively, are as follows:

(1) The President shall preside at all meetings of the members and of the Directors. He shall be the chief executive officer of the Corporation and see that all orders and resolutions of the Board of Directors are carried into effect. He shall sign all documents requiring the signature of any officer of the Corporation. He shall submit a report of the Corporation to the members and Directors at their annual meetings, including all matters within his knowledge which the interests of the Corporation may require to be brought to their attention.

He shall perform such other duties as may be prescribed by the Board of Directors.

(2) The Vice-President shall discharge the duties of the President if the President is absent or unable to perform them, and shall perform such other duties as may be required by the Board of Directors.

(3) The Secretary shall sign all Certificates of Membership and all such other documents as may be required to be attested by the Secretary. He shall keep a record of all the proceedings of the Corporation; a list of names and addresses of all members, and the dates when they became members and when they ceased to be members. He shall give notices required and perform such other duties as generally pertain to the office of Secretary, or as may be prescribed by the Board of Directors.

(4) The Treasurer shall keep account and have custody of all money and property of the Corporation. He shall countersign all checks and other commercial papers and any other documents required by the Directors to be signed by him. In general, he shall perform the duties generally incident to the office of the Treasurer of a corporation, and perform any other duties prescribed by the Board of Directors. He shall give bond in such sum and with such surety as the Board of Directors shall prescribe for the faithful performance of his duties.

SECTION 3.—VACANCIES

A vacancy occurring from any cause shall be filled by the Directors electing any officer to serve until the next annual meeting and until his successor is elected and qualified.

ARTICLE V

COMMITTEES

SECTION 1.—STANDING COMMITTEES

The standing committees shall be as follows:

(1) The Executive Committee.
(2) The Committee on Qualifications.
(3) The Committee on Examinations.
(4) The Committee on Finance.

They shall be constituted and their duties shall be as follows:

(a) The Executive Committee shall consist of the President, Vice-President, and Secretary. It shall represent the Board of Directors and perform the functions and duties of such Board during intervals between the meetings of the Board; and shall keep a record of its actions, which shall be reported to the Board of Directors for approval. Any action of the Executive Committee shall be effective until the next meeting of the Board of Directors, but shall have no further force and effect thereafter unless approved by the Board of Directors.

(b) The Committee on Qualifications shall consist of three Directors and shall be chosen by the Board of Directors. It shall be the duty of this Committee to investigate and pass upon the qualifications of applicants for membership.

(c) The Committee on Examinations shall consist of not less than three nor more than seven Directors, to be elected by the Board of Directors. It shall be their duty to make arrangements for and conduct examinations.

(d) The Committee on Finance shall consist of the Treasurer and two Directors, to be chosen by the Board of Directors. It shall be the duty of this Committee to study and make recommendations to the Executive Committee for the raising and budgeting of necessary funds for the operation of this Corporation.

SECTION 2.—SPECIAL COMMITTEES

The Board of Directors, the Executive Committee, and the President shall each have the power to appoint such special committees as may be necessary to aid them in the discharge of their duties, and to perform such special services as may be assigned to them.

ARTICLE VI

MEMBERSHIP CERTIFICATES AND SEAL

SECTION 1.—FORM OF CERTIFICATE

The form of certificate showing membership shall be that form appearing in the Record Book preceding the By-Laws, and marked for identification in ink as follows:

Form of Certificate, Cancelled the_____ day of _____, 19_____.

SECTION 2.—OWNERSHIP OF CERTIFICATES

Before the delivery of the certificate the applicant to whom the Corporation proposes to deliver it shall sign an agreement to the effect that the certificate shall remain the property of the Corporation and will be returned by him to the Corporation in event the certificate is revoked and his membership cancelled; and that in event it remains in force and effect until his death, it shall at his death become the property of his estate.

SECTION 3.—SEAL

The seal of this Corporation shall be a circular disc containing on the periphery thereof the following: "Ind. Bd. of Gen'l Practice," and in the center a caduceus and the word "SEAL" across the center and through the caduceus—all so constructed as to impress the entire seal in raised letters upon paper.

ARTICLE VII

REVOCATION OF CERTIFICATE

SECTION 1.—IPSO FACTO REVOCATION

If the license to practice medicine of any physician holding membership in this Corporation is re-

voked or suspended, or if he is expelled from his County Medical Society, such event shall operate as a revocation of his Certificate of Membership and of the honor awarded him of "Diplomate of the Indiana Board of General Practice of Medicine"; and the Secretary shall thereupon cancel his name from the list of members.

SECTION 2.—REVOCATION UPON HEARING

The Certificate of a member may be revoked for cause upon a hearing before the Board of Directors in any meeting of the Board, or upon a hearing before the members in any annual meeting of the members, provided in either instance a quorum is present and a notice of charges has been given to the member and to the Directors or other members (depending upon whether the Directors or members conduct the hearing) at least thirty days before the meeting. The member shall be entitled to be heard and to present evidence in his own behalf. The charges shall be sufficiently definite and clear to inform the accused member of the facts charged against him. He shall have the right to question any person who testifies against him. It shall require a vote of at least two-thirds of the members or Directors present at the hearing to revoke the Certificate of any member.

SECTION 3.—CAUSES FOR REVOCATION

The violation of the principles of medical ethics of the American Medical Association, misrepresentation or fraud in obtaining a Certificate, conduct unbecoming to a physician or discrediting to the Board shall constitute causes for revocation upon hearing.

SECTION 4.—RETURN OF CERTIFICATE

If the Certificate of any physician is revoked ipso facto or upon a hearing, the physician shall immediately return the Certificate to the Secretary. If he fails to do so the officers of this Corporation are authorized to institute legal proceedings to compel the return thereof.

SECTION 5.—DECISION REGARDING REVOCATION SHALL BE FINAL

All decisions of either members or Directors on questions of revocation shall be final. No right of action shall exist against any Director or member by reason of any act or conduct in connection with any such hearing, and all statements made in such a hearing shall be regarded as privileged and confidential.

ARTICLE VIII

MISCELLANEOUS

SECTION 1.—FISCAL YEAR

The fiscal year shall be the calendar year.

SECTION 2.—WAIVER OF NOTICE

Any member may, in writing, waive the mailing and giving of any notice required by the laws of Indiana or the By-Laws of this Corporation.

ARTICLE IX

AMENDMENTS

By-Laws may be adopted, amended or repealed at any meeting of the Directors at which a quorum is present, by a majority vote, provided notice of the proposed amendment is given in writing to each member of the Board of Directors at least five days before the date of the meeting.

Committee on Establishment of Board of Certification for the General Practice of Medicine.

MEDICINE TODAY

To the Editor:

Recently several cases of tinea capitis were observed which had been treated with fractional doses of x-ray. Examination of the patients under the Wood light two to eight months after treatment revealed that the infection was neither inhibited or cured. This is in accord with the known fact that x-ray does not destroy the fungi present in the hair shaft.

The treatment of choice for the human type of fungus infection of the scalp produced by the organism Microsporon audouini is that of complete x-ray epilation, which eliminates the fungi present in the hair and exposes the scalp for treatment of the cutaneous infection.

The use of x-ray in fractional doses for this condition is to be condemned, because it has no therapeutic value and prevents the application of the proper epilating dose because of the increased danger of producing a permanent alopecia.

H. H. Rodin, M.D.

AGREEMENT FOR MEDICAL CARE TO VETERANS

between

INDIANA STATE MEDICAL ASSOCIATION

and

THE VETERANS ADMINISTRATION

The agreement between the Veterans Administration and the Indiana State Medical Association for medical care to veterans with service-connected disabilities was approved by the Veterans Administration on August 30, 1946, as effective August 1, 1946. The original plan for such care originated by resolution in the House of Delegates of the Indiana State Association, in session January 21, 1946. It was submitted for approval to the component county societies on March first, together with data upon which the societies were able to submit a schedule of fees considered to be equable. The approved plan and composite fee schedule was accepted by resolution of the State Council on April 21, 1946, and submitted to the Veterans Administration.

The plan which became effective on August first in Indiana is essentially identical to the one established in Ohio on July 1, 1946, and effective in other states. The execution of such plan is by agreement and not by contract. Services rendered to veterans under the agreement is on a voluntary basis by physicians who wish to be appointed as fee-designated physicians by the Veterans Administration and to receive pay for such services according to the accepted fee schedule. Choice of physician remains the privilege of the veteran.

AGREEMENT BETWEEN THE VETERANS ADMINISTRATION AND THE INDIANA STATE MEDICAL ASSOCIATION FOR THE MEDICAL CARE OF VETERANS WITH SERVICE-CONNECTED DISABILITIES

1. It is the purpose of the Indiana State Medical Association to collaborate with the Veterans Administration in a manner which will provide the best possible medical care for veterans residing in the State of Indiana.

2. The Indiana State Medical Association will request all of its members to participate in a state-wide program whereby physicians in private practice will render medical services (examinations, treatments, and counsel) in such cases as may be authorized by the Veterans Administration.

3. The Indiana State Medical Association will submit to the Veterans Administration a list of members who desire to provide services for eligible veterans in home communities of such veterans.

4. The physicians so listed may be appointed as fee-designated physicians of the Veterans Administration.

5. Such list may be augmented from time to time as additional physicians indicate a desire to participate in the program.

6. By notice in writing, a physician may at any time request that his name be removed from the list of fee-designated physicians.

7. Fees for medical services in authorized cases shall be paid by the Veterans Administration to the physician rendering the service in accordance with the fee schedule, which is attached hereto and made a part of this agreement. It is understood that unusually involved cases and services not scheduled will be subject to review by the Indiana State Medical Association and for recommendation to the Veterans Administration as to the appropriate fee.

8. The Indiana State Medical Association will assist the Veterans Administration in establishing for examinations and treatments a list of competent specialists who meet the qualifications for specialists of the Veterans Administration.

9. Lists submitted by the Indiana State Medical Association will be broken down by counties or districts, in order that the veteran for whom services are authorized may select a physician practicing in his home community.

10. The Veterans Administration will handle administrative and clerical details in connection with the authorization of examinations or treatments and the maintenance of records; and will arrange for transportation of the veteran if necessary.

11. When authorizing treatment, the Veterans Administration will furnish to the veteran proof of such authorization and a list of fee-designated physicians in the county or district in which the veteran is located in order that he may select his own physician for the services authorized.

12. The Veterans Administration will review reports of examinations and services to determine their adequacy. No fees will be paid by the Veterans Administration for reports which are not acceptable to the Veterans Administration nor for services rendered in unauthorized cases.

13. The Indiana State Medical Association will establish one or more boards of review composed of physicians. It shall be the duty of such board to review reports which are deemed by the Veterans Administration to be inadequate, or which do not meet the requirements of the Veterans Ad-

ministration; to recommend, at its discretion, the disqualification of any physician from further work with the Veterans Administration whose work is found by the board to be incomplete or unsatisfactory; and to advise and assist the Veterans Administration on other matters within the scope of this program.

14. The Indiana State Medical Association does not propose to make any charge for any service rendered to the Veterans Administration under this agreement.

August 1, 1946
(Effective date of this agreement)

Signed on behalf of the Indiana State Medical Association by:

Charles F. Thompson, M.D., Chairman,
Committee for Medical Care to Veterans.
William H. Garner, M.D.
A. S. Giordano, M.D.

August 15, 1946

ACCEPTED:

Signed on behalf of the Veterans Administration by:
R. C. Kidd,
Director, Supply Service.

Dr. J. E. Ferrell, president of the Indiana State Medical Association, appointed the following committee on August 1, 1946, to act on behalf of the State Association under the above agreement:

Charles F. Thompson, *Chairman*,
Indianapolis;
A. S. Giordano,
South Bend;
William H. Garner,
New Albany;
Vance Chattin,
Washington;
Frank B. Ramsey,
Indianapolis.

The State Association has acted as an agent on behalf of its members and now presents the plan for their consideration and voluntary participation with the assurance that free choice of physician on the part of the veteran and fundamental patient-doctor relationships have been protected. It furthermore is obligated by the agreement:

(1) To request members of the state association to voluntary participation in the plan to render care to veterans in the State of Indiana.

(2) To submit to the Veterans Administration a list of the members of the State Medical Association who agree to participate in such a program.

(3) To assist the Veterans Administration in establishing a list of competent specialists in the various counties and districts throughout the state.

(4) To appoint a Board of Review consisting of members of the state association, whose duties would be:

a. To act in an advisory capacity to the Veterans Administration with regard to problems in the care of veterans and the improvement of their medical care.

b. To review reports of findings which are returned as inadequate by the Veterans Administration.

c. To make recommendations with regard to the disqualification of any members of the state association whose services are considered inadequate by the Veterans Administration.

An understanding of the following definitions according to regulations of the Veterans Administration is necessary for the execution of the above agreement:

Veteran: Any male or female honorably discharged from military service who has served during any war period or so-called "emergency period," such service having been in the Marine Corps, the Army, the Navy, or the Coast Guard, or who has served during a peacetime period and is receiving a pension for a service-connected disability. Note: The Merchant Marine is not included, and an individual is not properly a veteran until after the date of his discharge.

Fee-designated Physician: Any doctor holding the degree "M.D." or "D.O." and holding a license from his state to practice medicine who has agreed to cooperate with the Veterans Administration and to render his service on a fee basis.

Service-connected Disability: One which has been adjudicated by the Veterans Administration as incurred in service or aggravated by service.

Presumptive Service-connected Disability: One in which the available evidence including the veteran's statement is sufficient to insure ultimate adjudication as service-connected.

A request for an out-patient treatment by a veteran for other conditions within two years of his discharge from service may be favorably considered upon a detailed statement of the claimant as to the nature of the injury or disease suffered in service and containing evidence warranting a tentative conclusion that the condition requiring treatment had its origin in or was aggravated by service.

Any veteran in a violent stage of mental-nervous disorder must be committed to a state institution or temporarily confined in accordance with the state law before being transferred from the custody of the state to a veterans' hospital.

A copy of the fee schedule and a card indicating his willingness to participate in such plan is to be placed in the hands of each member of the State Association.

Medical Panorama by the Associate Editor

MEDICAL SERVICE PLANS are rapidly expanding—now organized in thirty-three states and in process of organization in eight others.

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THE DOCTORS' PREFIX BILL in Missouri requires anyone using the word "Doctor" or "Dr." before his name to affix words or letters after his name designating the degree or the type of practice in which the individual is engaged.

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THE MILWAUKEE COUNTY MEDICAL Society and Woman's Auxiliary put on the outstanding lay education program of *all* time. Under the title "Centennial Hall of Health," in celebration of the 100th Anniversary of the society, a week-long session was presented, consisting of seventy scientific exhibits, a series of lectures, radio broadcasts, and demonstrations. More than thirty thousand, including ten thousand children, attended.

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NEW A.M.A. SETUP now provides for division of activities into three fields: medical science, medical economics, and public relations. Recommendations by Raymond T. Rich and Associates, following study of public relations, methods, and policies include: Expanded program of Health Education. Employment of high-grade lay economist to reinvigorate Bureau of Medical Economics. Coordinate public relations function through executive assistant who would become chief spokesman of A.M.A. policies. Presumably Dr. Fishbein's activities are to be confined to scientific editorship—a progressive transition, no doubt, dependent in no small measure upon whether or not the wily mustang of medicine accepts the bit.

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CO-OPERATIVE HEALTH FEDERATION of America, recently organized, seeks to consolidate forces for establishment of "consumer controlled" medical care plans. Another grouping of "crusading advocates" allied with various supporters of compulsory health insurance programs, they hope for "rapid and all-inclusive changes in the medical world." Endorsement from the National Conference on Co-operative Health Plans of the Government Health Program, and further suggestions for the new Wagner-Murray-Dingell Bill signpost the route they will travel. Their approval will be distinctly effective in gathering support for bureaucratic tendencies and government medicine.

"CALIFORNIA CARAVAN" is the radio expression of the California Medical Association's initial program for the air waves. A fifty-two week series has been planned in support of voluntary forms of sickness insurance. The program is dramatized and honors various localities in the state in re-enacting historical events. The object is "to tell a suitable story in an interesting fashion and thus let the public in on plans for the spread of voluntary prepaid medical services."

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OKLAHOMA STATE ASSOCIATION is putting on a "bang-up" campaign of health education through paid advertising combined with press releases. Selected national advertising agency. Will run quarter-page ad in seventy-seven daily and twenty-four weekly papers, once a month, for one year. Hope, through positive approach, to convey medicine's story to people. Central theme: "How well do you know your Doctor of Medicine?" Cost: special assessment $25 a member, approximates $25,000. A great deal more of this is needed.

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THE SEVENTY-NINTH CONGRESS passed the finish line without too much regret on the part of the medical profession. Some two hundred fifteen bills, bearing on health questions, remained as sleepers. The talk of a Special Session, for the moment, seems idle. However, such a session could well see revival of bills promoting the so-called "President's Health Program." There can be no doubt, however, that the next session will again present many of the old, and some new, bills pertaining to health. The pattern again will not be favorable to the American way of medical practice.

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UNDER THE TITLE: "The Next Ten Years in Medicine"—Roads to Regimentation or Pathways to Freedom?—the Medical Society of the County of New York has inaugurated a very valuable series of articles in *New York Medicine* on the "likely or desirable development of social, economic, and political aspects of medicine in the next decade." These are products of distinguished physicians in various fields and represent "every shade of social opinion on medical problems." In other words, free reign is given to express opinion. Valuable, if only to stimulate interest, such articles have an additional treasury of facts to stimulate the younger generation in medicine to think clearly and to recognize what may lie ahead.

VETERANS OF WORLD WAR II are being enrolled on an individual basis in a number of prepayment medical care plans and Blue Cross plans.

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EIGHTEEN STATES and the Territory of Alaska have adopted Basic Science Laws. New York and North Carolina anticipate joining the list before long.

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MEDICAL ORGANIZATION and economics are receiving their proper recognition in Michigan, where the State Medical Society, in cooperation with Wayne University and the University of Michigan, have concluded a program of lectures before their medical students. All state medical societies could well emulate this example.

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THE EDITORIAL BOARD of *The Illinois Medical Journal* has recommended and the Council of the State Medical Society approved prizes of $100 for the best-written article or editorial, and $200 for the outstanding reported original work published in *The Illinois Medical Journal*. The competition is open to members of the state society only. Object: Stimulation of the members to contribute scientific articles for publication.

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LOS ANGELES COUNTY MEDICAL Association adopted an indoctrination course for new applicants for membership. It deals with state medical laws, malpractice prophylaxis, ethics, courtesy, history, accomplishments, and aims. Attendance required at course of lectures. Object: Impress upon young physicians and new arrivals the value of membership and secure active participation in society work. Progressive!

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THE NEW CASTLE COUNTY Medical Society of Delaware is highly incensed, and rightly so, over the action of the Wilmington City Council in raising annual medical license fees from $10 to $50. In addition to the fact that such a reprehensible practice, in any amount, is a new wrinkle, there is no justification whatever for such an exorbitant extortion. Simple consideration of the enormous amount of charity work extended by the profession in any community should be enough to wipe out any idea of local taxation for the dubious privilege of doing such work. Such action reaches a new low for common decency; it hits a new high for stupid, disgusting ingratitude in a community whose civic servants appear bereft of any of the qualities of ordinary propriety. An equitable adjustment should be found in adequate compensation from the taxpayers for services rendered their community medical patients.

YALE UNIVERSITY School of Medicine, acting on the suggestion of the Connecticut State Medical Society, has instituted a campaign to implement and amplify the establishment of an Institute of Occupational Medicine and Hygiene. In addition to studying the problems of industry and conducting research in this special field, particular attention will be paid to the training of specialists in Industrial Medicine.

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DELEGATES OF THE KENTUCKY State Medical Association authorized the contribution of $5,000—$1,000 each for five years—to a Medical Student Loan Fund. Object: To help needy and worthy students to secure medical education, who are willing, upon agreement, to take a location in a rural section of the state. Additional funds from individuals and agencies were solicited. Total to date $11,000; six loans authorized, three in effect for this year.

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FOLLOWING THE LEAD of the American Academy of Pediatrics, in its national survey of child health services, the Oregon State Medical Society and the Connecticut State Medical Society have approved a similar study on a state level. Four main fields will be investigated: Hospital facilities; Community Health Services; Distribution, Qualifications and Activities of Professional Personnel; and Pediatric Education. Similar studies are now under way or will be launched in every state in the nation.

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MICHIGAN STATE MEDICAL SOCIETY, through its Council, has taken a definite stand on "defining a specialist." They have recognized that there are a great many experienced, highly-qualified men in practice who are not certified by specialty boards. These men frequently meet opposition in hospital appointments and recognition by governmental agencies. They have, therefore, recognized as a specialist one who qualifies under any of the following headings:

1. A diplomate of a specialty board.
2. A Fellow or an Associate Fellow of the Colleges of Physicians or Surgeons.
3. Members of the official organizations of the various specialties, such as the American Roentgen Ray Society.
4. Professors or associate professors in recognized medical schools.
5. Chiefs of the special services in accepted hospitals.
6. In addition to the above-named categories, individual doctors of medicine who are qualified by experience to do specialized work may be selected by a special committee, composed of the officers of the local county medical society and the district councilor, who shall act as chairman.

THE MEDICAL SOCIETY of the State of Pennsylvania has for the past five years been presenting educational and dramatic films before lay audiences. Such programs, if developed along national lines, would be a most valuable method of carrying medicine's message to the people.

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THE PLEA THAT THE YOUNGER members of the medical profession concern themselves actively with county, district, state and national medical affairs, voiced by the retiring president of the A.M.A., Roger I. Lee, should be heeded. Those who reap the harvest should sow the seed. The necessity for active, alert, interested young members in positions of responsibility, if recognized and acted upon, should stimulate dormant committees and somnolent societies. The interests of the future rather than the memories of the past require the infusion of new blood.

TWO MILLION, FIVE HUNDRED THOUSAND dollars is to be raised to build a research center in Hot Springs, Arkansas, to study the causes and cures of arthritis, by the National Arthritis Foundation.

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A FEW PERTINENT FACTS concerning alcoholism, brought out in a symposium before the Westchester County Medical Society (New York), revealed: fifty million people in the United States use alcoholic beverages. Six per cent become excessive drinkers. Seven hundred fifty thousand become addicts. Two and a quarter million drink excessively. Cost, per year, of caring for adults: thirteen million dollars—twenty-five million to maintain drunken persons in jails; one hundred seventy million to handle crime associated with excessive drinking. In 1944, the United States spent over seven billion dollars for alcoholic beverages, which is 4½ per cent of the national income.

GENERAL EISENHOWER PRAISES MEDICAL DEPARTMENT ON ITS 171ST BIRTHDAY

Before an estimated crowd of more than one thousand, General Dwight D. Eisenhower paid homage to the Army Medical Department on its 171st anniversary on July 27 at Army Medical Center in a coast-to-coast radio broadcast. General Eisenhower praised the Medical Department for its great successes before, during, and since World War II.

"Even when viewed only from the narrow standpoint of battle line efficiency, the Medical Department was an invaluable asset to our commanders of this war," General Eisenhower stated. "In the recent European campaign thirty thousand more wounded men were treated, healed and sent back to the front line than were numbered in the entire average strength of the Medical Department of that theater."

General Eisenhower heaped praise on the department for the "moral effect upon our fighting men of a human, devoted, efficient Medical Corps. Unbounded appreciation and admiration were freely given by combat soldiers to their comrades of the Medical Department," he stated.

"These sentiments were best expressed by the unanimous insistence of our front line regiments that their medical detachments be awarded a battle badge equivalent in its implication to the one that decorated the combat infantry. A greater military accolade than this, no department, no service, no unit could receive."

Major General Norman T. Kirk, the Surgeon General, declared that even though combat is ended, the Army retains its responsibility for keeping the soldier healthy and fit for duty. He described the Army doctor as the soldier's best friend and most intimate confidant.

"When war struck, the Army Medical Department suddenly became the family physician and the nurse for the majority of the youth of this nation," he said. "This responsibility was accepted without equivocation. We will continue to be not only physician but friend and confidant of all men in our charge—seeking not to minimize but to enlarge our responsibilities.

"We have helped win wars. We have helped preserve the Republic. We have implemented every other arm and service. It is better to look forward now into that new age of which we have seen the thunder-filled dawn."

"SHELL SHOCK" STUDY SHOWS FEWER CASES IN WORLD WAR II

Hysteria—the so-called "shell-shock" of the first world war, although probably a majority of its victims never heard a shell fired, persisted on a greatly diminished scale among American troops in the last war, according to an announcement from the Surgeon General's Office.

It was predominantly a mental malady of the last generation. Essentially it is manifested as a syndrome which simulates, without organic basis, some pathological physical condition. A victim will develop, for example, a paralyzed arm, but physical examination shows that the paralyzed area does not follow any single nerve or group of nerves. A man may be suddenly stricken blind but nothing wrong can be found with his eyes or optic nerve.

A hysteric is not consciously faking. For all practical purposes his arm is really paralyzed or his eyes sightless. Questioning often will reveal that the victim has had a hard blow on the arm or gotten a bug in his eye. If such a condition is not recognized it may persist for years and the organ involved may actually become useless permanently through disuse.

At about the time of the first world war this was common enough both among the military and civilians. On the part of the soldier it was an unconscious flight from danger. A hysterically paralyzed arm was a means of running away without suffering any of the penalties.

Shortly after the war psychiatrists began to report that no hysterical cases were coming to their offices any more. Instead they were getting more and more cases of so-called "anxiety neurosis," an overwhelming fear without specific physical manifestations. It was explained that the pattern of reaction of the individual with a somewhat unstable nervous system was changing with the changing times. Hysteria was a disease of a simpler environment. This persisted into the second World War. They talked of "anxiety neuroses," "combat fatigue," and the like. For the most part they were right. But, according to a study just reported by Lieutenant Colonel David B. Davis and Captain John W. Bick, of the Army Medical Corps, about one out of five of more than one thousand neuropsychiatric cases returned to one American Army hospital from overseas was actually a victim of hysteria.

"It is evident that hysteria was not of infrequent occurrence in World War II," they conclude.

What's Going On In Indiana by the Executive Secretary

Greetings! "What's Going on in Indiana" makes its debut in this issue of THE JOURNAL. Written by the executive secretary, it will appear each month and will report important activities within your state medical organization. Its purpose will be to give the news, briefly and concisely—so busy doctors may keep informed.

—ISMA—

Against Socialized Medicine. The platform of the Republican party in Indiana comes out unequivocally against socialized medicine, in these words: "We oppose the proposed socialization of the practice of medicine as an invasion of the rights of our people by regimentation of an honorable profession." The Democratic party's state platform is silent on the subject.

—ISMA—

No Medical Quacks. The 1946 Indiana State Fair was free of "doctors" in white coats hawking cure-all medicines. The reason: The council of the I.S.M.A. passed a resolution asking that the fair management refuse to sell concession space to patent medicine swindlers. Copies of the resolution were sent to Governor Gates, Lieutenant Governor James and Fair Manager Orval C. Pratt. These officials agreed that the public should be protected against medical quacks.

—ISMA—

Veterans' Care Status. Doctors will be asked, if they haven't already by the time this appears in print, whether they wish to participate in the state program for medical care of veterans of World War II. An agreement, which included a fee schedule, was adopted by the Council and forwarded to the Veterans Administration at Washington. Word was received early in September that the VA had approved it. A veteran needing medical service must get an authorization from the Indiana VA office, and with it he will receive a list of doctors in his community who are treating veterans. He may choose any one of them. The physician will bill the Veterans Administration which will pay him. This plan for care of veterans by private physicians was devised by Indiana-born General Paul R. Hawley, chief medical director, Department of Medicine and Surgery, Veterans Administration, and is operating in many states.

Prescription Service. Free "home town" prescription service for all veterans receiving treatment for service-connected ailments in Indiana (when the medical care program gets under way) is another of General Hawley's arrangements. Worked out with the Indiana Pharmaceutical Association, the plan provides that prescriptions and sick room supplies may be obtained by eligible veterans at 1,100 neighborhood drug stores. This new system will relieve physicians of the trouble of mailing prescriptions to VA hospitals, and it will expedite the procurement of medicines.

—ISMA—

The Nurse Shortage. Shortage of nurses has plagued doctors and hospitals for some years. Without sufficient nurses, patients do not receive needed care. With the present personnel inadequate, how are proposed new hospitals to be staffed and operated when they are completed? Medicine is so vitally affected that the Council decided something should be done about it. The Council chairman was directed to appoint a committee to study the problem and suggest a plan. What can the profession do to help solve the problem? If you have any suggestions to offer, send them to Cyrus J. Clark, M.D., 6325 Guilford Avenue, Indianapolis 5, Indiana, the committee chairman.

—ISMA—

Kaadt Diabetic Institute. As this column was written the Kaadt Diabetic Institute at South Whitley, Indiana, was under fire from three sources. 1. Dr. Charles F. Kaadt was slated to appear before the State Board of Medical Registration and Examination to answer charges of "gross immorality in connection with his practice of medicine, surgery, and obstetrics," filed by the Indianapolis Better Business Bureau. 2. Dr. Peter S. Kaadt, brother of Charles and now reported to be operating the alleged diabetic treatment institute, was cited to appear before the Division of Hospital and Institutional Services, State Board of Health, to face charges of operating a hospital to the detriment of the general public, and in violation of the regulations of the division and terms of the hospital licensing law. 3. An exposé of the diabetic "cure" by *The Indianapolis Star* which sent Robert E. Johnson, a non-diabetic, to the institute to collect facts for a series of articles.

The Indiana State Medical Association extends to you a hearty welcome to its annual session, in Indianapolis, October 29, 30, and 31, 1946.

Military News

Following his recent release from the Army, Dr. Herbert L. Joseph, of Indianapolis, has accepted a residency in dermatology at the Indianapolis City Hospital.

Lieutenant William A. Koontz, of Indianapolis, reports that he is now with the 35th Fighter Group in the Pacific, and that he probably will remain in service for approximately another year.

Information has been received that Lieutenant Joseph L. Sheridan, of Indianapolis, is now on the Japanese Island of Kyushu, with the 118th Station Hospital.

Captain J. B. Bennett, of Warren, has informed THE JOURNAL that he was separated from the Army Air Corps on July 21, 1946, after having spent three years in that branch of the service. He has resumed his practice in Warren.

Thirty-seven months' service in the Army is the record established by Dr. John H. Mader, of Indianapolis, who was recently discharged with the rank of major. He was with the A. A. F. in Madison, Wisconsin. Doctor Mader is now with the Veterans Administration, at the Cold Springs Road Hospital, in Indianapolis.

Major Donald J. Caseley, formerly of Winamac, is now associated with Dr. George J. Garceau, at 508 Hume Mansur Building, in Indianapolis, in the practice of orthopedic surgery. Doctor Caseley was in service with the Army for thirty-nine months. He served in the ETO for two years, with station and general hospitals, and also spent six months at the Tilton General Hospital, at Fort Dix, upon his return to the United States.

Dr. E. H. Hare, of Indianapolis, was named manager of the Indianapolis Cold Springs Road Veterans Hospital, in an announcement made by Merrill D. Cummins, regional Veterans Administration manager for Indiana. Doctor Hare, a native of Hamilton County, has been connected with the Veterans Administration since 1922 when he joined the staff as a general examiner. After serving as chief of the Out-Patient Service he was appointed clinical director of the Veterans' Administration Hospital in 1941, a position he held until 1944, when he was appointed chief medical officer. Doctor Hare has served as acting manager of the hospital since April first of this year.

Captain A. Ebner Blatt, formerly of Indianapolis, has set up practice in Oklahoma City, Oklahoma, following his release from medical service.

Following five years' service in the United States Army, Dr. Meredith B. Gossard has moved to Fairmount, where he will establish his practice.

Captain William P. Marshall, of Indianapolis, plans to locate in Kalamazoo, Michigan. Doctor Marshall was separated from the Army on July thirteenth, after twenty-four months' service, fourteen of which were spent in the Pacific with the 233rd General Hospital.

Recently released from the Navy, Commander Robert K. Walker, of Indianapolis, has resumed the general practice of medicine at 413 East Thirty-fourth Street, in Indianapolis. Doctor Walker spent forty-six months in the Navy, of which twenty-eight months were served overseas, in the Pacific theatre, including Guadalcanal, New Zealand, Philippines, and the Hebrides.

Dr. Ernest Price, of Waldron, has opened an office in Danville following his recent release from service. He is a graduate of the Indiana University School of Medicine, and served on United States Marine Hospital staffs during the war. During his service in this country Doctor Price was stationed at Seattle, Washington; San Francisco, California; and Louisville, Kentucky. Aboard the Coast Guard troop transport *U.S.S. Cavaher,* where he served for sixteen months as senior assistant surgeon, Doctor Price saw action in the Marianas, Leyte, Lingayen Gulf, and Zambales. His ship was torpedoed in January, 1945.

Four years' service as a commander in the United States Naval Reserve has been completed by Dr. R. G. Burman, of Jeffersonville, who plans to reopen his office in Jeffersonville. Doctor Burman served at the Bethesda, Maryland, hospital before being transferred to the Deep Sea Diving School at the Washington Navy Yards. Aboard the *U.S.S. Pelias,* a submarine tender, he saw action in the Pacific campaign, and was with the Fifth War Patrol, in the South China Sea area, on the *U.S.S. Haddo* submarine. Upon his return to the United States, Doctor Burman was assigned to the University of Louisville, on the V-12 program, and then was transferred to the submarine base at New London, Connecticut, where he served for fifteen months as medical department chief.

A Certificate for Meritorious Service has been awarded to Dr. Paul S. Pentecost, of Richmond, who served as camp surgeon of the 89th Infantry Division of the 354th Regiment, from June 1, 1945, until November 1, 1945. The certificate reads: "Dr. Pentecost displayed great energy, efficiency, and devotion to duty in carrying out tasks of redeployment operations of the 89th Infantry." Doctor Pentecost served with the rank of Major, and he was stationed in the Chancor base section in Europe.

Captain T. F. Schlaegel, Jr., of Indianapolis, returned from service on June seventh, and is now on terminal leave. Doctor Schlaegel graduated from Indiana University School of Medicine, in May, 1942, and entered the Army in July, 1943. For one year he was stationed at Camp Blanding, in Florida; then he joined the 176th General Hospital, at Camp Barkeley, Texas, in August, 1944, serving in the E.E.N.T. section. With this unit he went overseas, landing in La Haye du Puits, in Normandy, in October, 1944. He remained with this unit until the end of the war in Europe, when he was transferred to the 11th General Dispensary, in France, as ophthalmologist. Later the unit was sent to the Philippines, for staging, then to Fukuoka, where he had an opportunity to visit the Kyushu Imperial University, which had remained intact, and where the effects of the atomic bomb were studied. He was also at Kobe, Japan, and en route he went through Nagasaki. Doctor Schlaegel says he found Japan very interesting, and his impression was that they were doing an excellent job in the occupation thereof. He has a Research Fellowship in Ophthalmology, at the Indiana University Medical Center, beginning October first.

Captain Alton H. Ridgway, of Indianapolis, returned to inactive status on July twenty-third, following his recent military career. He entered the service in December, 1943, at Carlisle Barracks, and took a three months' course in military neuropsychiatry at Mason General Hospital, in Brentwood, New York. After spending three months at the Brooke General Hospital, in San Antonio, Texas, he joined the 240th General Hospital, with which he went overseas, in November, 1944, and which was sent to France, where its main point of operation was at Nancy. Doctor Ridgway served as a neuropsychiatrist with this unit, until October, 1945. In November, 1945, he went to Germany where he joined the 16th Station Hospital, which was later set up at Wiesbaden, then at Passau, and then at Amberg, Germany. There they encountered a minor diphtheria epidemic among our troops. He left the hospital in June, and arrived in the United States in July, 1946. He participated in the Rhineland campaign, and was on detached service for about six weeks with field evacuation hospitals. Doctor Ridgway plans to take a surgical residency, and then enter missionary service.

Major Henry S. Tanner, of Indianapolis, has resumed the practice of orthopedic surgery, at 1010 Hume Mansur Building, in Indianapolis, subsequent to his release from the Army. Doctor Tanner spent four years at the Walter Reed General Hospital, and for the last six months he has been in the Mariana Islands and Japan, with the 309th General Hospital.

Major Charles F. Gillespie, of Indianapolis, entered service in July, 1944, and three months later went overseas with the 116th Evacuation Hospital as a member of the surgical service. They landed at Marsailles and served through the Rhineland and Central European campaigns. In May, 1945, the hospital was designated to take care of the typhus patients at Dachau, where there were 2,500 cases of typhus among its 30,000 inmates, the epidemic having developed shortly before our forces got in there, and had been brought on by the transfer of D.P.'s from other concentration camps. These inmates were dying at the rate of one-hundred-fifty a day, but a month later the rate had dropped to eight or ten a day.



Actual photograph of bodies being hauled from Dachau as a result of starvation and typhus prevalent among the D.P.'s at this camp.

After clearing up the situation at Dachau the 116th was scheduled to go to Japan, but the war ended and the unit returned to Germany, where it was disbanded.

Major Gillespie then was assigned to the 130th Station Hospital, at Heidelburg, where he served on the surgical service, doing septic surgery and gynecology. After four months he was again transferred, this time to the 98th General Hospital, in Munich, where he remained until his return to the United States on August second, having served overseas for twenty-one months.

Turning from the grim picture at Dachau, Major Gillespie did have an opportunity to visit London, England, and Lake Geneva, Switzerland, and pointed to Lucerne as being the prettiest city he had seen throughout his whole European tour.

Doctor Gillespie is entering the practice of obstetrics and gynecology, at 3209 North Meridian Street, Indianapolis.

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MAJOR FLICK ONE OF THE FIRST TO VISIT HIROSHIMA

Major John J. Flick, of Indianapolis, started his Army duty prosaically enough in August, 1943, but after his transfer to the 311th General Hospital, in January, 1945, things began to happen. At that time the hospital was in parallel training in California. The unit went overseas in March, landing in Manila, where the hospital was to be set up. The hospital building itself was prefabricated, but the furniture was non-existent. So even the officers turned into carpenters, building benches, chairs, desks, operating equipment—in fact, all their furniture—out of any kind of wood they could obtain, including packing cases, wooden crates, and materials secured from the Filipinos, this being done at the hottest time of the year, with the temperature registering 119 degrees where they worked. At the end of fourteen days they accepted their first patient. Doctor Flick saw a great many more patients between that time and the following August, when he was ordered to duty with the 42nd General Hospital, which was in bivouac in Manila. Immediately after he joined the 42nd, they sailed for Japan, landing there before V-J Day! The 42nd General Hospital has the distinction of being the first large organized unit to enter the Tokyo-Yokohama area. On the thirtieth of August they set up an aid station in Yokohama to take care of evacuated prisoners of war.

On September seventh Major Flick was assigned to the Atomic Bomb Investigation Committee, as assistant to Colonel A. W. Oughterson, Deputy Surgeon, Supreme Command, and they flew to Hiroshima, where they remained a week, making superficial casualty surveys among the Japanese.

They returned to Tokyo on the fifteenth, and shortly thereafter were sent to Nagasaki, where they spent three weeks formulating the casualty survey program. Upon his return to Tokyo, Doctor Flick became chief of the E.E.N.T. Section of the 42nd General, which at that time was set up in St. Luke's International Hospital. He remained there until his return to the United States after seventeen months of overseas' duty.

A vivid picture of Major Flick's experiences in his flight to Hiroshima can be gained only by a description thereof in his own words, an account which depicts how atoms into ruin hurl'd, would banish not only Hiroshima, but all the world:

"It is difficult for me to describe the thoughts that were racing through my mind on that morning of September 7, 1945, as our party loaded into the four big C-47's at the Atsugi Air Field for the flight to Hiroshima. There was a little anxiety, of course, but the predominant feeling tone of the moment was one of high excitement born of the adventurous character of our mission into the 'unknown.' 'The first to visit Hiroshima!' What strange sights would we see? What was this monstrous perversion of civilization? The throbbing of the motors added a grim touch as we clung to our bucket seats, but our hearts were high with the anticipation of things to come. 'We are off to see the Wizard!' shouted one of the party.

"At 8:30 A.M., thirty minutes after the take-off, we were over Fuji, thrusting its bald, mahogany summit into the clear morning air. The orderly echelon formation of the other three planes formed a beautiful picture against the mountain. The sun glinted sharply from the rice paddies that slid beneath us. Farther south verdant mountains presented themselves backlighted by the rising sun in the east. We flashed over bays and inlets with their tiny sampans, and at times the broad expanse of the open Pacific shimmered before us.

"At 12:30 we removed the great sidedoor of the C-47 and lay on our bellies on the floor, peering at the scene below in order not to miss the great moment, cameras in readiness. The ship was heaving and tossing a great deal due to currents of air that had followed the big typhoon, and most of us felt a little disturbed in the stomach. Each fought the nausea in his own way, and many grim glances were exchanged. Soon we emerged from a cloud and a series of tall peaks to see the city of Hiroshima, spreading its finger-like deltas toward the sea.

"The pilot threw the ship into a steep bank, so that we could look directly down. We circled the city three times. A huge, circular, blighted area could be seen to cover the larger part of the city toward the north portion. This zone, three or four miles in diameter, was a crusted debris of twisted steel and ashes, with chimneys here and there thrusting their blackened shafts out of the rubble. The streets were clear except for the automobiles and streetcars standing where they had stood when the explosion occurred. It was as if the moving picture of a dynamic scene of metropolitan activity were suddenly stopped, and we were viewing the 'still,' seared and blackened. Innumerable vultures sailed over the ghost-like city, but no other sign of life could be seen. Thoughts of the lost city of Atlantis passed through my mind. The realization of the immensity of the destruction wrought by a single stroke weighed upon me. Almost uncontrollable waves of nausea passed over me. I rested my head on my arms as I lay and longed for the flight to end. It was 1:30 when our pilot skillfully maneuvered our ship onto the shell-torn air strip at Iwakuni, thirty miles away. We gathered our party together to make plans for our visit to the city of Hiroshima on the morrow." Thus ended the first flight to Hiroshima.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

News Notes

Dr. R. Lee Boling, formerly of Indianapolis, is now in practice in St. Petersburg, Florida.

Dr. John G. Rhorer has opened an office in Marion, for the practice of medicine.

Dr. A. Earl Applegate has located in Frankfort for the general practice of medicine. He formerly practiced in Lafayette.

Dr. Kathryn Campbell Susott, of Boonville, has closed her office there, and has gone to Mitchell Field, Long Island, where she and her husband will establish their residence.

Dr. Lee Brayton has announced that Dr. Jack Hall has become associated with him in the practice of medicine, at 3342 North Illinois Street, Indianapolis.

Dr. Oliver W. Greer, of Indianapolis, has moved to Denver, Colorado, where he is director of the Professional Service of the Veterans Administration. Doctor Greer was formerly connected with the Crippled Children's Division of the Public Welfare Department.

Dr. Lois Godersky, who has practiced in Flora for the past year and a half, has closed her office permanently. She has joined her husband, Dr. George Godersky, in Indianapolis, where he has a residency at the Indiana University Medical Center, following his recent release from the service.

Dr. Helen D. Van Vactor, of Indianapolis, is now associated with Dr. Edgar F. Kiser and Dr. Bernard D. Rosenak, in the Hume Mansur Building, in the practice of internal medicine. Doctor Van Vactor recently completed a residency in medicine at the Robert W. Long Hospital, in Indianapolis.

Dr. C. H. McCaskey, of Indianapolis, presented three papers at the Postgraduate Course in Ophthalmology and Otolaryngology, sponsored by the North Carolina Eye, Ear, Nose and Throat Society and the South Carolina Society of Ophthalmology and Otolaryngology, held at Hendersonville, North Carolina, September 16-19. The subjects discussed were: "Physiology of the Nose"; "Acute Otitis Media"; and "Significance of Hoarseness."

Dr. Michael J. Menza, of Edinburg, has closed his office there, to accept an appointment on the staff of the Niagara-Hudson Clinic in Buffalo, New York.

Dr. John Ellett, Jr., of Coatesville, has opened an office there to begin the practice of medicine. He is a graduate of the Indiana University School of Medicine, in 1945, and has completed his internship at the Methodist Hospital, in Indianapolis.

Announcement has been made of the appointment of Dr. Carl D. Martz, of Indianapolis, as medical director of the Cerebral Palsy Clinic at the Riley Hospital, under the State Board of Health's Division of Services for Crippled Children.

A familiar face will be missing at this year's annual session — one who had been a constant attender—that of Joe O'Meara, the well-known representative from Fort Wayne, whose passing left a vacant place within our circle.

For the first time in approximately twenty years, Dr. D. D. Jones, of Berne, has taken a vacation, and is taking an automobile tour of the Pacific northwest, the west coast, and a return trip via the southern route. Doctor Jones plans to be gone for an indefinite time.

Dr. J. R. Matthew, of North Judson, was elected National Commander of the American Expeditionary Fraternity of World War II, at its convention which was held recently in Columbus, Ohio. This organization was formed in Oxford, England, by hospitalized veterans of World War II.

Dr. James S. Noblitt, of Waveland, has retired after eighteen years of practice in Waveland, where he established an office in 1928. Prior to that he practiced in Bellmore for seven years, in addition to a one-year service as a member of the staff of the Sunnyside Sanatorium, in Indianapolis. Doctor Noblitt will make his home in Rockville.

Announcement has been made of the marriage of Miss Jane Austermiller, of Indianapolis, and Dr. C. L. Rice, of Logansport. The wedding took place on June twenty-first, in Louisville, Kentucky. They have established their residence in Shelbyville. Doctor Rice practiced in Logansport before he entered the service.



A NAME TO REMEMBER

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Dr. Robert M. Moore, of Indianapolis, Governor for Indiana of the American College of Physicians, has announced that there will be a regional meeting of the College at the Congress Hotel, Chicago, Illinois, on Saturday, November 16, 1946, in which Indiana physicians will participate.

Dr. William F. Hughes, Jr., of Indianapolis, is now associated with his father, in the Hume Mansur Building. Doctor Hughes, Jr., graduated from the Johns Hopkins University School of Medicine, in Baltimore, in 1938, where he has remained since that time and where he served as assistant professor of ophthalmology.

Dr. F. S. Crockett, of Lafayette, has been named a member of the United States Public Health Service Advisory Committee, to serve as a consultant to Surgeon General Thomas Parran and the Public Health Service Federal Council. The committee is composed of approximately one hundred ten physicians, educators, and social service workers. The first meeting was scheduled for September seventeenth, in Washington, to consider the administration of the new Federal Hospital Survey and Construction Act, under the direction of the Federal Security Administrator, Watson B. Miller.

INDIANA UNIVERSITY NEWS NOTES

Reactivation of the Medical Corps R.O.T.C. Unit at the Indiana University Medical Center, in Indianapolis, has been announced by Colonel J. E. Graham, newly-appointed head of the University's Military Department.

The Medical Corps unit, which furnished many of the officers that staffed the Thirty-second General Hospital, organized under the sponsorship of the medical center, was suspended during the war when medical and dental students were called into service, where they continued their training. Under the reactivation program, which will be effective with the opening of the dental and medical schools, students will be accepted for the R.O.T.C. unit on an advanced course basis.

The Military Department will be under the direct command of Dr. J. Neill Garber, of Indianapolis, associate in orthopedic surgery at the Indiana University Medical Center, who was recently appointed by the War Department as assistant professor of Military Science and Tactics at the medical school, and who was a major in the United States Medical Corps, where he served successively with the Thirty-second General Hospital in England, France, Germany and Belgium; and later with the 224th General Hospital in the Philippine Islands, and finally with the 361st Station Hospital at Kure, Japan.

Deaths

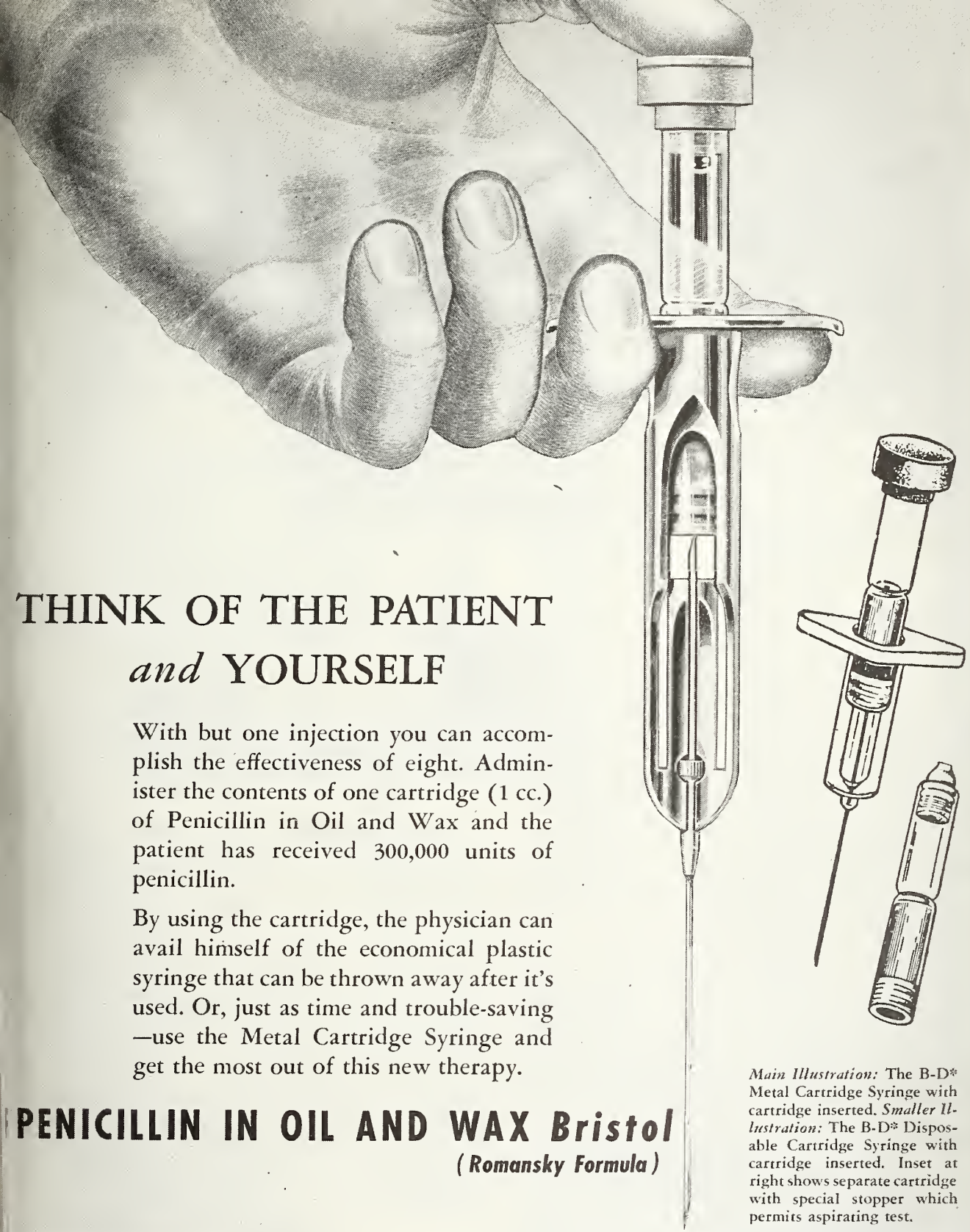
George W. Elliott, M.D., of Wabash, died on May twenty-third, at the age of seventy-three. He was a graduate of the Curtis Physio-Medical Institute, in Marion, in 1895.

Robert W. Hatch, M.D., of Indianapolis, died on September eighth, after a year's illness. He was forty years of age. Doctor Hatch graduated from the University of Minnesota Medical School, in Minneapolis, in 1932.

Lee F. Hunt, M.D., of Anderson, died on September ninth, following an illness of three days. He was sixty-nine years of age, and he had practiced medicine and surgery in Anderson for forty years. Doctor Hunt graduated from the Kentucky University Medical School, in Louisville, in 1903, and he was a member of the Madison County Medical Society and the Indiana State Medical Association, and was a Fellow of the American Medical Association.

James Lambert Beatty, M.D., of New Market, died on May thirteenth, aged eighty-seven. Doctor Beatty was a graduate of Miami Medical College, of Cincinnati, in 1881. He had retired from practice.

John Ray Newcomb, M.D., of Indianapolis, died September third, after a brief illness. He was sixty-six years of age. During World War I Doctor Newcomb was a member of the original staff of the Lilly Base Hospital, and he served as chief of ophthalmology on the Surgeon General's staff, in Washington, holding the rank of major. During World War II he served as chairman of the Marion County Procurement and Assignment Service, and he was vice-chairman of the State Committee for Medical Officer Procurement. He held the rank of colonel in the Army Reserve Officers' Corps at the time of his death. Doctor Newcomb was a graduate of the Medical College of Indiana, in Indianapolis, in 1904, and he was a member of the Indianapolis (Marion County) Medical Society, the Indiana State Medical Association, and the American Medical Association.



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Society Reports

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

August 12, 1946

Present: H. G. Hamer, M.D., chairman, Ben B. Moore, M.D., and Ray E. Smith, executive secretary.

The following news release for daily newspapers was approved:

Monday, August 12, 1946—"Artificial Respiration Saves Lives."

On the grounds that to continue the program would run the bureau in the red for the year, it was voted to discontinue the services of a paid radio script writer and actress. The present weekly radio program of American Medical Association recordings is to be continued.

The executive secretary was instructed to prepare all news releases, both for daily newspapers and the "Hints on Health" column for weeklies, and to handle the publicity for the exhibit at the Indiana State Fair and the program of the annual state medical association meeting in October.

The bureau directed the executive secretary to write to each county medical society secretary and ask for names of members who are willing to lecture on medical subjects or federal legislation. In addition, names of good speakers who appeared before the county medical societies during 1945-46, and their subjects, are to be requested. The information is to be used to set up a speakers' file in the Bureau of Publicity.

Request for speaker:

First or second Wednesday in September—Shelby County Medical Society, Shelbyville. Subject: "Public Relations." Speaker procured.

BUREAU OF PUBLICITY

August 26, 1946

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

A news release for general distribution, entitled "Medical Paintings Will Be Exhibited by State Doctors," which described the Indiana State Medical Association exhibition at the Indiana State Fair was approved.

Copy for the "Hints on Health" column for weekly newspapers was approved, as follows:

Week of September 2, 1946—"Ringworm of the Scalp."

Week of September 7, 1946—"Treatment of Warts."

Week of September 16, 1946—"Find Eczema's Cause."

Week of September 23, 1946—"Childbirth Deaths Cut."

Week of September 30, 1946—"Gallstone Symptoms."

Request for speaker:

September 11, 1946—Shelby County Medical Society, Morristown, Ind. Dinner meeting. Speaker obtained to talk on "Public Relations."

A letter written to county medical society secretaries asking for names, addresses and subjects of the best speakers during the past several years was presented.

LOCAL SOCIETY REPORTS

Boone County Medical Society members held a business meeting on September third, at the Witham Memorial Hospital, in Lebanon. A program committee was appointed, consisting of Dr. L. M. Headley, Lebanon, chairman; Dr. A. D. Schaaf, Jamestown; and Dr. C. G. Kern, Lebanon. Ten members were present.

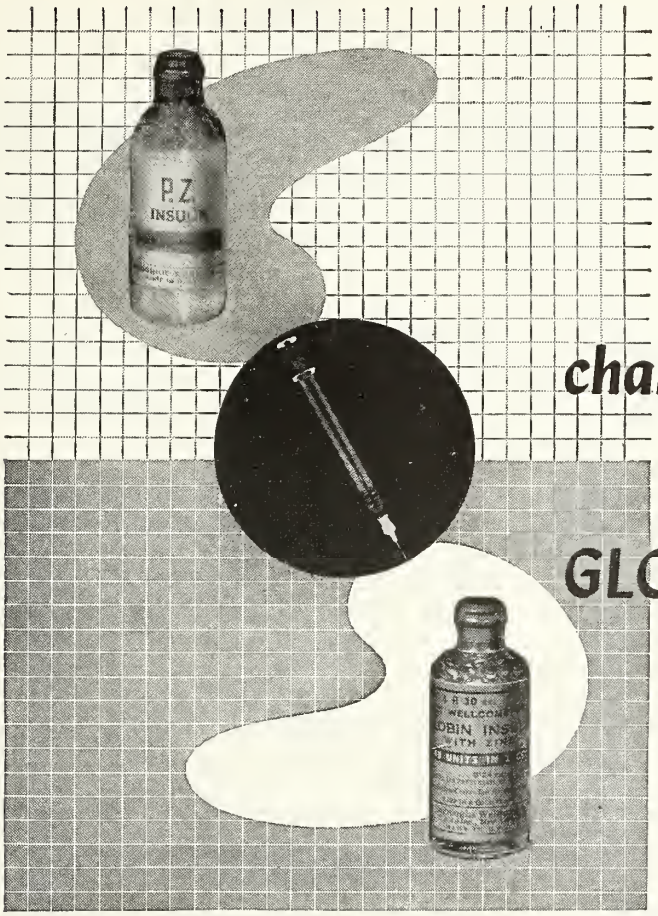
Elkhart County Medical Society members met at Hotel Elkhart, in Elkhart, on September fifth. The forty-five members present heard Dr. Howard B. Carroll, of Chicago, speak on "Cholecystic Disease."

Floyd County Medical Society members met at the New Albany Country Club, in New Albany, on September thirteenth. The speaker of the evening was Dr. Jesshill Love, of Louisville, Kentucky, whose subject was "The Problem of Cancer in General Practice." Twenty-one members and guests were present.

Greene County Medical Society members met at the Freeman Greene County Hospital, in Linton, on September twelfth. The twelve members present held a business meeting and general discussion.

Marshall County Medical Society members held a meeting at Plymouth, on September fourth. Twelve members attended the meeting, and heard Dr. H. D. Tripp, of Plymouth, discuss "Intestinal Obstruction."

Randolph County Medical Society members held a meeting in Winchester, on September eleventh. The sixteen members present heard Dr. J. R. Robison, of Winchester, speak on "Treatment of Hypertrophied Prostate."



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Putnam County Medical Society members held a meeting on September eleventh. Ten members and guests were entertained at a steak fry at the cottage of Dr. G. D. Rhea, at Reelsville.

Wabash County Medical Society members met in North Manchester, on September fourth, when twenty members were present. A discussion was held regarding the society's recommendations for a new hospital.

COUNCILOR DISTRICT MEETING

ELEVENTH COUNCILOR DISTRICT

The seventy-sixth semi-annual meeting of the Eleventh Indiana Councilor District Medical Association was held on September eighteenth, at the Veterans Hospital, in Marion. Dr. Max Adams, of Flora, who is district president, presided. Huntington was chosen for the spring meeting, which will be held on May 21, 1947. A clinical staff conference was held in the morning, and a business session followed the luncheon. The scientific program consisted of a discussion of "Out-Patient Services to Veterans," by Dr. D. R. Adams, of Indianapolis; "Mental Hygiene," by Dr. S. T. Ginsberg, of Marion; and "Psychosomatic Medicine," by Dr. David A. Boyd, Jr., of Marion. A picnic dinner was held on the hospital lawn, at 5:30, and the speaker of the evening was Ross Lockridge, of Indiana University, in Bloomington.

Books

RECEIVED

TECHNIQUE OF PSYCHOANALYTIC THERAPY. By Sandor Lorand, M.D., Member of the Faculty of the New York Psychoanalytic Institute, formerly Director of the Mental Health Clinic, Mount Sinai Hospital, and Lecturer, Columbia University. 251 pages. Price $4.50. Fabrikoid. International Universities Press, New York, 1946.

OPHTHALMOLOGY IN THE WAR YEARS. (Volume I) Edited by Meyer Wiener, M.D., Professor of Clinical Ophthalmology, Washington University School of Medicine; Honorary Consultant in Ophthalmology, Bureau of Medicine and Surgery, United States Navy. 1166 pages. Cloth. Price $13.50. The Year Book Publishers, Inc., Chicago, 1946.

A BIBLIOGRAPHY OF INFANTILE PARALYSIS, 1789-1944. Compiled by Ludvig Hektoen, M.D., Chief Editor, Archives of Pathology, and Ella M. Salmonsen, Medical Reference Librarian, John Crerar Library, Chicago. 672 pages. Fabrikoid. Price $15.00. J. B. Lippincott Company, Philadelphia, 1946.

PENICILLIN, ITS PRACTICAL APPLICATION. Under the general editorship of Sir Alexander Fleming, M.B., B.S., F.R.C.P., F.R.C.S., F.R.S., Professor of Bacteriology in the University of London, St. Mary's Hospital, London. 380 pages with 59 illustrations. Cloth. Price $7.00. The Blakiston Company, Philadelphia, 1946.

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—June, 1946

Diseases	*June 1946*	*May 1946*	*April 1946*	*June 1945*	*June 1944*
Tuberculosis, pulmonary	378	163	206	285	519
Tuberculosis, other forms	30	6	14	12	2
Chickenpox	263	297	327	162	182
Measles	1012	1957	2948	145	275
Scarlet Fever	165	225	359	219	192
Smallpox	6	14	2	1	....
Typhoid Fever	6	4	7	10	3
Whooping Cough	172	70	106	103	74
Diphtheria	21	36	41	24	13
Influenza	3	21	57	23	4
Pneumonia	17	22	20	6	4
Mumps	94	182	183	186	199
Poliomyelitis	9	....	1	7	1
Tetanus	2	....	2	1	....
Cerebro-Spinal Meningitis	6	10	15	7	18
Rubella	24	28	60	6	12
Ringworm of the Scalp	4	....	304	....	....
Tularemia	2	1	1	1	....
Undulant Fever	26	8	2	4	10
Impetigo	3	6	2	5	....
Erysipelas	1	1	4	2	....
Septic Sore Throat	22	23	17	1	....
Malaria-Acq. Outside U. S.	18	19	26	3	....
Encephalitis	1	1	....	....	....
Conjunctivitis	1	5	2	1	....
Rocky Mountain Spotted Fever	1	....	....	6	....
Vincent's Angina	1	4	....	....	1
Hookworm Disease	3	....	....	....	....

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

MONTHLY REPORT — JULY, 1946

Diseases	*July 1946*	*June 1946*	*May 1946*	*June 1945*	*June 1944*
Tuberculosis, Pulmonary	119	378	163	285	519
Tuberculosis, Other forms	5	30	6	12	2
Chickenpox	55	263	297	162	182
Measles	111	1012	1957	145	275
Scarlet Fever	35	165	225	219	192
Smallpox	5	6	14	1	.....
Typhoid Fever	30	6	4	10	3
Paratyphoid	3	.....	.....	.....	.....
Whooping Cough	101	172	70	103	74
Diphtheria	8	21	36	24	13
Pneumonia	9	17	22	6	4
Mumps	56	94	182	186	199
Poliomyelitis	21	9	.....	7	1
Meningitis, Meningococcic	7	6	1	7	18
Meningococcemia	1	.....	.....	.....	.....
Septic Sore Throat	15	22	23	1	.....
Tularemia	2	.....	1	1	.....
Undulant Fever	22	26	8	4	10
Amebic Dysentery	2	.....	1	1	1
Infectious Jaundice	1	.....	.....	5	.....
Impetigo	8	3	6	5	.....
Malaria acq. outside U.S.*	33	18	19	3	3
Vincent's Angina	5	1	4	.....	1
Rubella	1	24	28	6	12
Tetanus	2	2	.....	1	.....
Ringworm of the Scalp	168	4	.....	.....	.....

* Outside United States.

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PRESIDENT'S ADDRESS*

INDIANA STATE MEDICAL ASSOCIATION

JESSE E. FERRELL, M.D.
FORTVILLE

On January first it was my pleasure to assume the presidency of the Indiana State Medical Association. There were many problems to be solved which were vital to the welfare of every member of this organization, and indirectly every citizen of the State of Indiana; and in recognition of a much-needed hurried action, your official family endeavored to the best of its ability to get into high gear. As a result, great things have been accomplished, not by any one member, but by the concerted action of all upon whose shoulders this responsibility rests.

I am sure that every one of you realize that this has been a year of reconversion—the return of the members of this association from their loyal service to their Government, all eager to get back into civilian practice. Special effort has been put forth by all concerned, to hasten the rehabilitation of these men in every way possible. Even the association has offered financial assistance to everyone who might be in need thereof, but only two or three have applied for such assistance, which I believe is significant of the caliber of these men. They wish to establish themselves without such aid. I believe we can truthfully say that all they ask is a square deal from those of us who remained in civilian practice. From some quarters come reports that this has not happened, but the general over-all reception of these men has been favorable, and rightfully so. Where dissension exists, we hope that conditions will be adjusted to the welfare of all concerned.

In reviewing the past years of our activities, the workings of this organization have been rather routine, and we had developed a degree of complacency which almost put us on the rocks, but by the action and continual goading of our leaders, who were farsighted enough to see what a sword of destruction was hanging over American Medicine, plans began to be formulated to combat the evils we were facing, and by concerted action we have been able to overcome some, but not all of them; I speak, of course, of that old and much-discussed problem of "Socialized Medicine," which at the present has been silenced by our own representatives who have made a notable fight against it, and by other organizations who are friendly to the medical profession and who have had the foresight to see what a calamity it would be for all our people if such a program should ever be put upon the statute books of this nation, the greatest democracy in the world.

I believe we all realize that something needs to be done. A basic program should be instituted, but such a program must be formulated so that the administration will be kept in the hands of the smallest unit of our form of government, or in plain words, this program must start at the bottom and move upward, not start at the top and move downward. Have you read the Taft-Hill-Smith Bill? I believe that the medical profession could support it. There are certain changes that should be made, and I am reliably informed that Mr. Taft is asking the opinion of physicians for the explicit purpose of making the necessary changes. May I ask all of you to get a copy of this bill; read and study it; then if you wish, send your opinions to Mr. Taft. The reason that I am stressing this action is that we are going to be compelled to accept some type of a program, and I am sure that you would be much more pleased if you knew that you had some say in the formation of such plans.

After being discussed by your House of Delegates on several occasions, an insurance plan was finally adopted, and on January 27, 1946, at a called meeting of the House of Delegates, sanction thereof was granted by a unanimous vote, and I am happy to inform you that the company is now in operation in conjunction with the Blue Cross. Much credit should be given to the president of the company, Dr. W. U. Kennedy, and our attorney, Mr. Albert Stump. It has required an enormous amount of work on the part of these two men. I hope that we can predict a successful

* Presented before the General Meeting of the Indiana State Medical Association, at Indianapolis, on October 29, 1946.

future for the insurance company, but like all new ventures, there are many pitfalls to be encountered. I trust that those in charge will be able to steer this undertaking on the best course possible; also that it will accomplish the aims that were set for it at all times; and, that by so doing, we will be better able to counteract at least some of the vicious legislation that has been proposed to Congress.

One of the outstanding accomplishments this year has been the work of the committee that was entrusted the job of setting up the Indiana Board of General Practice of Medicine, Inc. This is a pioneering job from start to finish, for no other state has such a board. We should be very proud of this action, and every one doing general practice should be a member of this organization. You may ask the question, why belong? First, this was the only group in medicine and surgery which did not have an organization, and which is one of the fundamentals of all groups. Second, this opened up a field of postgraduate study, which will assist its members to keep abreast of the fast-moving panorama of scientific research, which will in turn aid us in the proper diagnosis and treatment of patients who entrust their health and lives to our care. The committee as a whole, and especially the chairman, is to be congratulated upon this fine accomplishment. May it become a nation-wide organization, that all general practitioners may reap the benefits thereof.

Another great problem that arose in the past few years is that of "better medical care for our rural population." This is a large and important undertaking. The Indiana State Medical Association, through its officers and special committee, has assisted in the work that has already been done, and will continue to assist as long as this emergency exists. Just what the final solution will be I am unable to state at this time. I think, as a great number of members also think, that after our citizens again get their feet on the ground, and reconversion is complete, that many of these problems, if things are properly planned, will smoothen out and that every one will be able to secure proper medical aid.

Along with this proposed program, let us not forget the shortage of nurses. This situation is one for which no solution has as yet been found. The question arises, how can more young women be induced to take up nurses's training? The fact is that from an economic point of view the business world offers immediate jobs, ofttimes without special training, and at an age when most girls have a desire to make their own way. After all, the desire of most young women is to get married, and they cannot see their way to face four years of hard training with expenses attached. I am keenly aware of the need for correction of this situation, and as a matter of suggestion I would like to propose that in addition to the already-established campaign of publicity on the subject, we offer the girls who wish to enter training a living wage during such period of training, and that the social aspect of their training be put upon a higher plane; and, further, if a distinction exists between the lower and upper classes, that it be done away with, and by so doing remove some of the stigma that most girls in training complain of, thereby making life during these impressionable years one of happiness—giving them confidence in themselves, and making them feel that they are doing their part in alleviating the sufferings of humanity, and that they are human beings, not merely robots.

The Indiana State Medical Association is pleased that an agreement has been reached with the Veterans Administration, whereby the physicians of this state can render service to the returned veteran, so long as the ailment is service-connected. Your specially-appointed committee has worked out a fair fee schedule for such service. A copy of said fee schedule and a contract will be sent to each member of this association. For further information on the subject I refer you to the October issue of THE JOURNAL. This is a duty that must be performed, and let no one shirk his responsibility, for along this line our enemies are watching our every move. If for any reason we fail, it will be chalked against us, and it will be one more wedge in their action to cause our downfall in our fight against the socialization of medicine.

Ofttimes the burden of carrying the load in our fight to retain our freedom seems almost unbearable. Heretofore, in years that are now history, medical men were very selfish for several reasons. One such reason was from the standpoint of ethics. The other main reason was that medical men were very skeptical. They possessed a certain ego based on the fact that their particular type of work in life was not to be questioned or discussed by mere laymen, thus building up a false sense of security among our very best men in the profession. But in the past few years this has all been changed. We now find ourselves fighting to hold our position in society, and are only too glad to have the friendship of the different groups of society. From our new way of thinking has sprung our medical service and public relations program. We are now encouraging getting together with other professional groups, having round table discussions with them—they give out their problems, and we discuss ours. In this way we have found that other groups have problems as well, and on hearing theirs, ours sometimes seem small in comparison. I hope that this type of public relations will be continued and developed to the fullest extent.

Another element that enters into good service for our association is that of criticism. Every individual and group benefit by constructive criticism. If you wish to criticize the management of this organization, which in the end may be all to the good, why not do so, for the profits reaped from such a program might be of great benefit to us all? Also, I believe that every member of this organization has in his or her mind some construc-

tive ideas that would be very beneficial to our cause, and I am sure that these would be welcome. But instead, I fear that too often our members keep silent, or offer a degree of criticism which brings forth a resistance, and no matter how good the suggestions may be, they are cast aside, which may in the end develop into so-called "cliques," which invariably spoil our whole democratic way of thinking. As matters are today, every individual of this organization must stand together in the fight against our common enemies, if we expect to survive.

In a final summation of our situation today, let me again reiterate that there are many problems confronting American Medicine; and if we are in the least backward in voicing our opinions, or fail to act on information we receive from not only our own medical service and public relations committee, but from information received from a similar committee of the American Medical Association, then American Medicine, as we know it, will be wounded beyond all aid.

In traveling over the state it is very noticeable that the average physician is complacent. He has been a very busy man in the past few years, and I fear that all of us have been lulled into a state of false security. We are all more or less in a daze, and it is hard to keep up-to-date with the happenings that concern us. To better understand this social revolution, we must take time to study and assimilate every move, ever remembering that conclusions must come quickly, for time is the essence. The task is great and action must take place as rapidly as possible.

The basic issues are now being pointed out, and they all fall into the same pattern, all turning to a contest between those who seek security, even if they have to give up freedom, and those who think that in the long run the security of the individual will be possible only if freedom is retained.

Gentlemen, you can't compel Americans into doing much of anything, but you can persuade them into performing almost any miracle, even that of winning two World Wars.

Skeptics have said that the voluntary plan for medical care did not succeed in Europe. Neither did democracy succeed in Europe. Let's cease groping around in irrelevancies. Let us direct these great forces of medicine—the individual physician, the public health officials, and those in the highly specialized health field who are rendering such great service, and even those doing public relations work, whose job is to kindle the imagination of the American people. As a parting word, let us get on with the job of providing the best medical care to our citizens, not through dictatorship and compulsion, but through the voluntary way of our true American Democracy.

ABSTRACT: PENICILLIN SPRAY FOR TREATING RESPIRATORY DISEASES

Inhaling penicillin spray is more economical and effective for infections of the respiratory tract than injecting the drug into the veins or muscles, according to the latest report appearing in the October 5 issue of *The Journal of the American Medical Association.*

Frank W. Morse, M.D., of Lawrencetown, Nova Scotia, says that by this treatment penicillin is placed at the site of infection and has not only a strong local effect, but is absorbed into the blood stream and aids the natural body defenses to overcome the condition. Moreover, "it also has a definite local soothing effect which relieves such discomfort as soreness in the throat, painful, frequent coughing, and the sensation of dryness in the mucous membranes."

The author maintains that the "penicillin seems to act in a more efficient manner when given by spray than by injection. It is common to give 160,000 units daily by the intramuscular route in pneumonia, whereas in treatment of one case of pneumonia in this series 40,000 units were given daily for four days, a total dosage of 160,000 units in all. In other words, the total dose in this case treated by spray would supply only one day's dose if given intramuscularly. This saving of penicillin is apparently due to the fact, that, first, the greatest concentration of penicillin is directly on the infected site, the air sacs; and secondly, it is absorbed into the blood stream and thus has a systemic effect as well."

Most of the twenty-five patients who were treated by this physician were infected during the influenza epidemic which began in this locality about January 3, 1946. There were only two failures in this series, which were due to the uncooperativeness of the patients.

Penicillin spray is produced by a hand-operated bulb atomizer. The patient inhales and then holds his breath, allowing the suspended penicillin to settle on the infected mucous membranes.

Personally convinced of the advantages of penicillin spray, the author summarizes them as follows:

1. The absence of toxicity in contrast to that of the sulfonamides.
2. The absence of dangers due to untrained personnel using the intramuscular route of administration.
3. The ease of transporting and caring for the materials, the atomizer, and penicillin.
4. The availability of materials. Atomizers can be easily obtained and are cheap. Penicillin spray can be purchased at a small cost.
5. Painless administration. This is an important factor in nervous or young patients.
6. The saving of penicillin.
7. The remarkably soothing local effect of penicillin spray in addition to its therapeutic effectiveness.
8. The pleasant taste of penicillin.
9. The absorption of inhaled penicillin. The fact that inhaled penicillin spray is absorbed and can attain an effective level in the blood suggests that perhaps sites of infection other than those in the respiratory tract may be treated in this manner.

An editorial in the same issue of *The Journal* states that penicillin spray is probably the simplest technic thus far employed for the treatment of respiratory conditions. "The results recorded are encouraging," it says, adding: "However, much more needs to be done on the subject of penicillin administration by inhalation before this procedure can be considered of established scientific merit. Controlled studies are necessary. Large enough numbers of patients with a single respiratory disease need to be studied and compared with similar groups treated without penicillin and with penicillin administered by the usual intramuscular route. Comparative studies should be made on the value and accuracy of the various types of nebulizers and on their effectiveness in delivering the penicillin where it will do the most good. Important also are careful studies on the optimum dosage of penicillin when given by spray, the preferred frequency of administration, and the most desirable medium for dissolving the penicillin."

GENERAL REFLECTIONS ON GERIATRICS*

W. D. GATCH, M.D.†

INDIANAPOLIS

This is the first meeting devoted to geriatrics ever held in Indiana. Dr. King deserves full credit for it. Its papers are grouped in two symposia—one on the evaluation of the mental and physical capabilities of aging people; the other on how best to utilize these capabilities in industry and elsewhere.

I shall speak briefly on some fundamental concepts on geriatrics as an introduction to the papers on special parts of it which are to follow.

How long should a human being be expected to live under ideally favorable conditions? Some writers contend that the normal span of life is one-hundred years or more, but this conclusion is based on very doubtful assumptions, such as that the total length of life of an animal should be five times the time it takes to reach maturity. Other writers contend that the real span of life—at least under average natural conditions—is about fifty years, because at that age the crystalline lens of the eye hardens, and in the female the menopause occurs. They point out that in a state of nature no one could live very long with a serious defect of vision because he could not protect himself from danger.

The average length of life under the conditions of civilized society is somewhere between these extremes. Defective eyesight is no longer a fatal defect, and the tremendous margin of safety which nature puts into the vital organs enables men, on the average, to live ten or fifteen years—in many cases a great deal longer—after they reach the age of fifty. What factors govern the duration of this extra extent of life?

The investigations of the late Alexander Graham Bell established the tremendous influence of heredity on duration of life. Agents in his employ interviewed a large number of centenarians. His hope was that he could discover something in the habits of these aged people which could be imitated by all who wish to live a long life. This hope was sadly disappointed. Many of the centenarians had violated almost every rule of hygiene and good conduct. Many of them had used alcohol and tobacco to excess. All of them, however, came from long-lived families. This investigation showed that longevity is an inherited characteristic and that environment and habits of living have far less to do with it than is commonly supposed. It depends upon inheritance of a good nervous system, of good arteries, of immunity to infection, and of resistance to neoplastic disease. We can, theoretically at least, breed a race of centenarians. We cannot by any improvement in environmental conditions or in medical care prolong the life of the average man of today to one hundred years. Life is like the flight of a bullet. Its possible length depends on the force which sets it in motion. By good care of a man, we may be able to keep him alive until the vital force he inherited is expended, but nothing we can do for him will keep him alive longer than that. This fatalistic view should not, however, make us think that whatever we may do for people over fifty is of but little value. It is really of immense value because it can keep most of them alive, reasonably happy, and very useful to society for many years.

It follows from the foregoing discussion that approximately at the age of fifty man enters the most critical period of adult life. Heretofore he has regarded himself as immortal. He is shocked when presbyopia and diminished physical vitality teaches him that this belief is wrong. Many men of this age resent what nature has done to them. Their pride forces them to show everybody that they can still "take it" as well as ever. This is why many of them do physical exercise and indulge in dissipation dangerous to their hearts; also why husbands at this age are apt to stray.

Man is a complex psycho-physical organism. His mind and body are inseparable. They should be mutually helpful. Either one can destroy the other. They are at war with one another in the sixth decade. Man has by then become a bundle of habits. In fact, his habits make up most of his life. To break up these habits, as every experienced physician knows, is a very unwise thing to do. In some cases it causes the actual death of the patient. In others it reduces him to a state of premature senility or actual dementia. I have often observed these dire consequences follow the retirement of elderly farming people to an easy life in town at the behest of their prosperous children. The easy life proves anything but easy for these poor people. They long for the daily routine of the farm, and for the companionship of their old cronies. They become introspective, miserable, decrepit, and often die in a year or two. California is filled with unhappy people of this kind who have moved there from the Middle West.

The war taught us that there is almost unlimited life in an old automobile if you use it properly. It also taught us that an automobile not used at all deteriorates far more rapidly than one which is constantly but reasonably used. The same is true of elderly human beings. They may have arthritis, defective vision, high blood pressure, coronary diseases, and other dreadful ailments, but they still can do a great deal of useful work, and will last a long time if their mental and physical powers are kept in proper daily use. I believe that how best

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to do this is the most important problem of geriatrics. Social and economic changes in our country in the last twenty-five years have made its solution difficult. Chief of these are: urbanization of the people; destruction of household and community crafts by methods of mass production; replacement of a settled community life by a life of wandering; the mechanization of entertainment; limitation of births so that large families of children have been replaced by small families or none at all.

Everyone of these changes has done much to make harder the life of the aging. When most of our people lived on farms and families were large and community life settled, the older people were useful and happy. They had an honored place in the family and community. Their life-long habits were not broken at the age of fifty. They were sure of the respect and support of their families in time of sickness or trouble. The artisans of the rural community—blacksmiths, shoemakers, carpenters, weavers, etc.—shared this settled and satisfying existence. The community furnished its own entertainment—the church, the school, the lodge, the political meeting. This happy way of life is gone forever for most of our people. It is gone even from most rural communities. A laborer of fifty is now considered too old to hold his job in the factory. He loses it, and with it his accustomed routine of living. His children, if he has any, may be living in distant cities. He may be divorced from his wife. He faces a life of loneliness, idleness, and neglect. What has society so far done to help him? A regular income from social security is about all. This, to my way of thinking, falls far short of meeting his needs.

It may even bring upon him the ills which a life of ease brings upon elderly farming people. What the man of fifty or past needs to keep him happy and alive, to occupy his time, and to preserve his self-confidence is a steady job which he is able to do. How to give him this job will require the cooperative efforts of physicians, labor leaders, industrialists, and legislators, as well as enlightenment of the public.

How to preserve the aging in a happy and useful existence is more a social than a medical problem. Too much medical care is now a chief peril to people over fifty. Too much attention, even though it is kindly, is bad for them. They resent it, because they do not want to be objects of pity.

HEALTH GUIDANCE IN ADVANCING YEARS*

WILLIAM F. KING, M.D.†

INDIANAPOLIS

The Indiana Legislature in 1945 adopted a provision in law requiring the Indiana State Board of Health to "provide facilities and personnel for research investigation and dissemination of knowledge to the public concerning the health of persons of middle and advanced age and diseases common thereto." Thus, we have the Division of Adult Hygiene and Geriatrics of the Indiana State Board of Health. One of the prime objectives of the division is to assist in bringing about a condition wherein every one may have the benefit of the best possible health guidance throughout all advancing years.

We believe that this is the first institute or conference on the subject of "Geriatrics" to be held by any state medical university or state board of health in the United States. We are hopeful that the discussions of this program and the knowledge derived from these discussions will be so helpful that other institutes and conferences will be held, and that such institutes and conferences will prove to be an important medium for the "dissemination of knowledge to the public concerning the health of persons of middle and advanced age."

Childhood was formerly considered the most critical period of life. Children were expected to be sick, to be deformed, and to die. Then about the turn of the century we discovered that childhood and youth were phases of life based on specific biological laws, and that aging was the law of life in childhood and youth as in maturity and age. The result of this discovery and its acceptance was the dramatic development of child hygiene and pediatrics. The most dangerous diseases of childhood were practically wiped out; the mortality of infants was reduced to a minimum; well babies and children were made healthier and stronger; and we entered what has been called the "Century of the Child." The expectancy of life has been increased from approximately forty-eight years in 1900 to approximately sixty-five years today, and we are now obliged to give some attention to the rapidly increasing part of our population which is reaching advanced years of life. We have considered the aged as hopeless victims of physical and mental deterioration, and we have too often treated them either as decrepit children or degenerated adults. In reality, the aged constitute a

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human species in their own right, not inferior specimens by any means, but full of potential energies and values which are now either largely repressed or wasted. The need to learn about aging is urgent. Longer life without health is not only an individual tragedy, but it is a social evil that constitutes a threat to national economy. Increased life with health and useful vigor may be made an increasingly valuable asset to society. The future course of events, whether toward economic destruction or toward a progressive enrichment of life, will depend largely upon the application and experience of medical knowledge to the aging. Such is the vast responsibility of Geriatric Medicine.

We are charged with the responsibility of setting up a program and pattern whereby the benefits of medical knowledge may be made available to the betterment of the health of persons of middle and advanced age. We are charged with the responsibility of helping men and women who are living longer to live better, and to be assured of opportunity to live more efficiently and more productively. We want to usher in the "Century of the Aged," both as the complement and the fulfillment of the "Century of the Child."

In order to arrive at a clear concept concerning geriatrics, it is important for us to consider the definition and the real meaning of some of the terms pertaining thereto. Geriatrics, which is derived from two Greek words meaning "healing of the old," is not a new specialty in medicine. It simply means the application of medical knowledge and clinical experience to the prevention and treatment of diseases and disabilities commonly occurring in the advancing years of life. Senility does not mean aging nor does aging necessarily mean senility. Senility is no more an essential part of aging than is rickets of childhood. Normal aging is senescence. Aging subjected to and changed by disease may become senility or abnormal aging. Degenerative diseases, so-called, are misnomers. There is no disease so peculiar to aging as to be known as being due to age itself or to any so-called "degenerative process of aging." Age is neither a visitation nor a penalty, but rather an accomplishment and a fulfillment. "It need not be just endured; it can be enjoyed."

In 1789, based on statistics of Massachusetts and New Hampshire, the only statistics available, the expectancy of life in this country was 35.47 years. In 1850, based on similar statistics, the expectancy was approximately forty-three years. In 1900 and 1902, based on statistics from the then registration area of the United States, the expectancy of life was a little more than forty-eight years. The 1942 statistics from the entire registration area of the United States show that the average expectancy of life is now approximately sixty-five years.

The most critical period of life today is that of maturity, the active and productive period which may be roughly designated as from thirty-five and forty to fifty-five and sixty years of age. It is in this period that so many of the diseases of later years have their beginning. It is largely within this period that senescence or senility is determined. It is in this period that the health guidance of medical knowledge and the health supervision of clinical experience can be made most helpful in preparation for advancing years.

Because of the rapid growth of our population beyond the median age of life there will be a corresponding increase in chronic illness, in disability and in physical and mental impairment. This is the challenge of increasing years added to life expectancy. It is possible that in years to come there will be a growing acceptance of the principle that the individual is not entirely free to do the things that may endanger his health because his carelessness or ignorance may threaten the social order of which he is a responsible member.

Such speculation is related to the task of medical and health organization and practice of today. We have just witnessed the tremendous development of medical care and health supervision programs in our armed services; we have seen the rise of organized efforts to provide health supervision in industry, medical care and health teaching in our schools and colleges, and prepaid medical care in our communities. If this means anything it surely means that we must translate medical knowledge and medical experience more effectively into living habits to better conserve the health and strength of our people at every age.

There is great need for added knowledge concerning the process of aging and the problems of the aged, based on clinical experience and biological research. This we believe will come with increasing interest on the part of the public and the medical profession in these processes and problems. But in the meantime we have the aging and the aged with us in ever-increasing numbers. We have also the accumulated knowledge and experience of medicine, both general and geriatric. By a practical application of present knowledge, through professional and public co-operation, we will certainly advance both the science and the art of geriatric medicine, and will, just as certainly, add to the comfort, efficiency, and happiness of our aging and aged people.

We know so little about a way of life for the aging man and woman which will avoid not only undue demands upon lessening capacity, but which will also avoid depressing restrictions upon full activity appropriate to each individual. This presents an urgent clinical problem to geriatrics as it endeavors to understand the possibilities as well as the liabilities of aging persons and to work out a pattern for living applicable to individual problems of aging.

We believe that the answer to the problem is three-fold. The first requirement is that we, all of us, acquire a more intelligent conception of aging and adopt a more realistic attitude toward

both the aging and the aged. Most of us have a prejudice against aging which in many cases extends to the aged as well. Clinicians do not always give the attention to patients over sixty which these aging persons merit. Our prejudice leads us to believe that the infirmities of age are inevitable and that "Nature must take her course," or that "Old age is just creeping up." Public prejudice requires that the old must give way in order that youth may have full opportunity, and for this we take refuge in the Biblical "three score years and ten" or in the saying, "You can't teach an old dog new tricks." A sane conception of aging as a normal biologic process, as an essential part of life, and a realization of the fact that wisdom is born of experience must lead us to conclude that if life actually ended at either the legal age limit of sixty-five or the Biblical age of seventy, the world would be much poorer in human accomplishment than it is today. Elderly people have well earned their right to the fullness of life.

The second requirement is that scientific study and research be directed to a greater knowledge, and thus to a clearer understanding of the processes of aging. We know a lot about the age of the human race and how man lived in past ages because money has been made available for continuous study, research, and exploration of the records of the past. Libraries are full of literature and references to the anthropological age of man, but there is practically nothing available as to the biology and psychology of growing old. It seems strange that the one thing that every one must look forward to is the one thing least understood. With public recognition of the importance of the problem, and with public support, scientific study and research will be mobilized in increasing measure to find the facts and discover the secrets of aging.

The third requirement is that all proved medical knowledge and experience be made available for the health guidance of men and women through all the years of middle and advanced age. The basis of health guidance in advancing years must be the periodic health examination with continuous medical direction and supervision. This is especially important to both men and women throughout the active and productive period of life, from thirty-five and forty to fifty-five and sixty years of age. It is true that physical examinations, so-called, have not been too satisfactory in the past to either the patient or the physician. This is due to the fact that both the patient and the physician have been superficial and careless; have been unwilling to take the time and make the effort necessary to get a true picture of what the patient may be doing to himself or for himself, or what he may do to better prepare himself for the demands of the aging process.

A physical examination should be more than a superficial inspection—more than a determination of the presence or absence of disease. It should be, in fact, a health consultation between the individual and his physician in which both the patient and the doctor talk over and study all matters that concern the health of the patient. It should be a health consultation in every meaning of the term. This means that both the physician and the patient should not only be interested, but should take whatever time and make whatever effort necessary to obtain a true health inventory of the patient, a correct measure of the ability of the patient to stand up under the strain of physical and mental exertion, and to detect any beginning functional or organic change in order to guard against damaging effects, as far as possible. Pediatricians have shown that healthy and well babies and children can be made even healthier and stronger, and thus be better fitted to meet the demands of adult life. Constructive medical guidance and health supervision applied to adults throughout the critical years of maturity should make apparently well men and women healthier and better prepared to add useful, happy life to added years.

The age period from thirty-five and forty to fifty-five and sixty, the period of active productivity, is not only the most critical and dangerous, but this period is by far the most significant in preparation for healthy, happy old age. Because of this the value of continued health guidance through this period is obvious. Early and prompt detection and recognition of any and all beginning changes or variations from normal makes early intervention and prevention possible. Early recognition and treatment of precancerous conditions may prevent later malignancy. Proper instruction and care in diabetes may prevent dangerous complications. Adequate treatment in pernicious and other forms of anemia may prevent serious changes in the spinal cord and in the heart. A knowledge of heart conditions with avoidance of sudden or heavy strain may postpone coronary or cerebral difficulties. Early recognition of gastric lesions may enable the prevention of more serious and damaging complications. Early and timely removal of foci of infection may prevent the development of later malignant conditions. All these are but a few examples of preventive geriatrics translated into health guidance throughout the fateful years when men and women are most in need of such helpful guidance. If to these more direct measures there be added measures of adult hygiene, mental hygiene, proper and adequate nutrition, helpful advice as to habits, work and rest, recreation, and correction of abnormalities, then health consultations can be made distinctly worth while. After all, the prime objective in a health examination or consultation is to enable the individual to meet the daily demands of life safely and wisely at his age level, in harmony with his environment, and to conserve and maintain the highest possible state of health throughout all the years of his life.

Any consideration of adult hygiene or health in aging brings us inevitably in contact with every phase and every activity of life. Since age at any

level is the sum of all that has gone before, so the problems of age at any given time are the sum of all the problems of all the yesterdays of the individual. Thus, health guidance in maturity and through advancing years becomes the responsibility of not only the physician and the public health administrator, but also of the economist, the sociologist, the employer in industry, the educator, and the government representing all of these as well as the aging themselves.

Most physicians agree that idleness and lack of purpose are the greatest enemies of the aged, and that forced retirement from active participation in the daily affairs of life often becomes a one-way ticket to senility and premature death. Incapacity, physical or mental, does not come overnight or with any designated birthday.

Incapacity can often be prevented or checked by supervision and adjustment. There always have been and always will be a great number of jobs for which elderly people are better fitted than younger ones. What is required, of course, is a recognition of the potential value of the skill and experience that comes with the years, and an adjustment of working conditions to utilize these values. Much that is great and enduring in the world, in art, literature, science, invention and statecraft has come from men and women past the Biblical three score and ten.

Benjamin Franklin had much to do with the framing of the Constitution of the United States at the age of eighty. Oliver Wendell Holmes wrote many of his finest court decisions in his late eighties and retired from the Supreme Court at ninety-one. Tennyson wrote "Crossing of the Bar" at eighty-three. Nicholas Murray Butler recently retired from the Presidency of Columbia University at eighty-three. The football man of the year is still Amos Alonzo Stagg, of the College of the Pacific, at eighty-three; while a great figure in baseball, Connie Mack, still manages the Philadelphia Athletics at eighty-four. These are but a few of the many thousands of men and women who down through the years have shown the potential value of good life added to long years.

It seems plain that both a study of the problems of aging and a practical program for enabling men and women to use and enjoy the added years of life is a new challenge to not only the medical profession, but to all of us. Our approach to old age and senescence must change from passive defense and appeasement to active offense and confidence. Sometime, and in the near future, as we believe, age must be rated by health and ability rather than by birthdays, and people who survive or exceed their life expectancy must not be treated as statistical errors.

Out of the confusion and loss of war should come some very plain lessons to guide us in the future. One of these definitely deals with our aging population.

Because younger men and women were needed for armed service, older men and women, in unprecedented numbers, were brought into the war effort, and at ages far above both the legal and traditional age of retirement. These thousands of elderly men and women not only gave valiant and efficient service, but in so doing they proved their right to be considered a part of the manpower, a part of the human resources of the nation.

We welcome you today to this discussion of "diseases of advancing years," of "Aging as an Industrial Health Problem," and of the place Geriatric Medicine will have in meeting the social and economic problems of a rapidly aging people. We have tried to indicate some of the objectives of a program of adult hygiene and the part the individual, the public, the health departments, and the medical and allied professions must have in meeting these objectives. We hope you will find both inspiration and help in being here.

Everlasting youth is a fallacy and a wishful dream; but everlasting health is a reality, possible of accomplishment.

AMERICA CELEBRATES CENTENNIAL OF SURGICAL ANESTHESIA

Thus was the theme of an exhibit arranged by the Centennial Committee of the Indiana State Medical Association and the Indiana Association of the History of Medicine. This legend accompanied an exhibit of portraits of Henry Hill Hickman; Crawford Williamson Long; Horace Wells; Charles T. Jackson; William T. G. Morton; and Dr. John Collins Warren, who did the first public operation under ether anesthesia; and Oliver Wendell Holmes, who suggested the terms "anesthesia," "anesthetic," and "anesthetist."

"And the Lord caused a deep sleep to fall upon Adam, and he slept, and he took one of his ribs and closed up the flesh instead thereof . . .". Gen. 11:21.)

On October 16, 1846, W. T. G. Morton used sulfuric ether in a public demonstration at the Massachusetts General Hospital, a date recognized as the birth of painless surgery.

Others before Dr. Morton had experimented with anesthetic agents, among them—

Sir Humphrey Davy, in 1800, published researches on nitrous oxide, suggesting its use to eliminate pain in surgical operations.

Henry Hill Hickman, in 1824, produced anesthesia (partial asphyxiation) by administering carbon dioxide and nitrous oxide, and performed minor operations.

Crawford Williamson Long, of Athens, Georgia, gave ether as an anesthetic in 1842, but did not proclaim it.

Horace Wells, Hartford, Connecticut, used an "exhilarating gas" for tooth extractions as early as 1844, but failed in a public demonstration.

Charles T. Jackson, of Boston, claimed credit for suggesting the use of sulfuric ether to Dr. Morton.

The agents were here from the beginning of time, and came to fruition in the year 1846.

CERTAIN ASPECTS OF GERIATRIC MEDICINE*

EDWARD J. STIEGLITZ, M.D.

WASHINGTON, D. C.

I come before you with little certain knowledge, but with many ideas which are based on justified suspicion. An attempt to define geriatric medicine when it is still so young and in the state of growth is sure to be incomplete. Geriatric medicine has a future; it is not static. Although we can see some of its potentialities at the present time, there is reason to believe that there are others as yet unrevealed. In simplest terms, geriatric medicine is that part of the practice of medicine concerned with the health of the aging and the aged. You will note that I said health and not the diseases of later years. My reason for this deliberate change from the usual definition of a subdivision of the practice of medicine will be apparent later on.

Geriatrics is but a part of the larger science, gerontology. Gerontology is the study of the aging, and as a scientific field it is divided into three parts. It includes those problems concerned with the biology of the aging as a process or series of processes. Geriatrics is its second division; the clinical application of our knowledge of the biology of senescence to both normally and abnormally aging men and women. The third area is that pertaining to the social and economic problems introduced by older factions of the population.

These three broad divisions are intimately related to one another although their study requires widely divergent disciplines and techniques. In the first category we are concerned with the cells and tissues of man. The cell, as the ultimate unit of life, is the unit on which our attention must be focused. Geriatric medicine deals with man as the indivisible unit, because the most important implication of the word "individual" is that the person is indivisible. The last subdivision of gerontology is a field of sociology in which we are concerned with a still larger unit, society and the effects of age upon its constitution and economics. Nevertheless, society is composed of individual men and women.

These three fields are pragmatically related as well as theoretically. It should be obvious that the more we know about the biology of senescence the better we can practice clinical geriatric medicine; and the more fully we understand the biological capacities and limitations of elderly people, the more intelligently we can attack pressing social problems.

Today, however, we have been asked to concentrate our attention upon the clinical phases of this immense field of study. We must therefore resist the temptation to digress into some of the fascinating side roads. The importance of geriatric medicine has but recently been recognized.

This morning you heard something about the changes in the structure of the population of the United States. Although aging is as old as time, the study of the aging of a given individual has been ignored until recently. It is the recent changes in our population which have forced this upon our attention. Attention to aging has not been voluntary on the part of the majority of the people. Statistical data points out that the life expectancy at birth has increased from forty-seven years in 1900 to about sixty-five years at present, but I do want to add one or two figures. In 1900, 17 per cent of our national population was forty-five years old or older; in 1940, 26½ per cent were forty-five or more, and by very conservative projection, it is estimated that by 1980 over 40 per cent of our population will exceed forty-five years of age. The median age of our population increased two and one-half years in the single decade from 1930 to 1940; from 26.4 to 28.9 years in these ten years. Such a tremendous rate of increase in the age of a nation makes the immensity and urgency of the problem so obvious that we can no longer ignore it. Not only is the problem urgent; it is also unprecedented. We have no previous paths to follow. Previous shifts in population structure have all been in the opposite direction. Wars, famines, and pestilence have tended to eliminate the elderly and led to younger rather than older average age in populations in the past. Such is the situation in Europe today.

I recently had an opportunity to talk with an individual who had just returned from Germany, who said that within the next year or two the average age of the European nations which were actually involved in the destruction of war would drop very markedly. The older people, who were driven out of the cities by the bombings all over Europe, are dying in hordes. They are unable to survive the hardships. So America and Australia, which has a greater life expectancy than we have (we are not yet the best nation in the world so far as longevity is concerned), will be in an entirely different position from Europe and Asia in so far as the average age of populations are concerned. This is significant in connection with future planning and our role in the international economic system.

The most urgent problems from the social point of view are: (1) the question of employment of older persons vs. the dole, or whatever else you want to call it. This facet of the problem is extremely important. The discussion later on this afternoon regarding industrial health in relation to senescence will reveal the potential usefulness

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of the elderly. The major tragedies of the older individual are consciousness of uselessness, inability to find employment and satisfaction in accomplishment, and failure to be self-supporting, at least in part. Awareness of uselessness is a much greater tragedy than a little stiffness in the joints, dimming of the vision, lessened endurance and the like. (2) The second urgent problem presented by our aging people is that of the tremendous and rising costs of chronic diseases. If a man dies of pneumonia it is an immediate tragedy for his family and community, but that type of wound heals quickly as far as the community is concerned. But an individual crippled with arthritis or surviving for twenty years as a paralytic is not just a transient tragedy, but a terrific and prolonged drain upon the family and the community. (3) The serious threat of politics must not be forgotten. When the politicians become aware of the proportionate number of votes in the older age groups, they will promote a whole series of most outrageous schemes which will "out-townsend" Townsend. Then we may wish for the good old days of coal, automobile, and railroad strikes. (4) Lastly, conserving the mental and physical health of local and national leaders is vastly important. Such men are always mature individuals. Judgment can come only with experience, and experience depends upon duration of life. The youngster, no matter how brilliant and how educated, simply has not had time to accumulate experience. The potential value of older members of society has never been realized, and certainly never fully utilized. Conservation of the health of elder statesmen, teachers, and leaders is an enormously important responsibility of the medicine of tomorrow.

The scope of geriatric medicine depends upon what we make it. Geriatrics is much more than the mere care of the decrepit senile. If geriatric medicine meant nothing but the insurance of comfort for feeble, senile dependents, I am sure we would have no interest in it whatever. Such would be a sterile field. Geriatric medicine includes *all* the clinical problems of the aging and the aged. The processes of later maturity, senescence, may be normal or abnormal. Special questions in nutrition, physiology, psychiatry, and all the facets of human biology are created by senescence. These are the concern of geriatrics.

When does geriatric medicine begin? Aging, which is change, is continuous and insidious. Aging is a part of living. It starts with conception and ends only with death. Nevertheless, geriatrics must begin somewhere in adult life. It is notable that clinical manifestations of senescence usually become readily detectable somewhere in the neighborhood of forty, although these more obvious changes are preceded by years of subtle asymptomatic alteration. It is therefore pragmatic to set the beginning of geriatric medicine at approximately the age of forty. Sometimes we need to consider senescence earlier, sometimes much later. We must not be too dogmatic about the age of forty, for there is considerable variation in the rate of senescence.

The processes of aging are not symmetrical. There is a difference between the rate of age change in the different species, as you all know. A three-hundred-day-old rat has approximately the equivalent biologic age of a thirty-year-old man. Also within the same species there occurs great variation in the rate of aging change between different individuals. We are not necessarily of the same biologic age as our chronologic age, except by coincidence. Furthermore, within the same individual there is variation in the functional and structural aging of different parts. We are not of the same biologic age throughout. At different phases of the life span the aging of certain structures is accelerated, as at puberty and the climacteric. I am sure all of you know of instances of old men with old hearts, but with young ideas. We are not symmetrical in any sense. The biologic age of an individual is not to be defined simply; it is the mean of many composite ages of different structures and functions.

The primary objectives of geriatric medicine are preventive. If it is sensible for the child to make preparation to become an adult, it is equally sensible for the young adult to prepare for senescence. Too often awareness of senescence is suddenly thrust upon people. They are unprepared for the requisite limitations and equally unready to develop their fine potentialities. It should be an important function of clinical medicine to assist people in their preparation for later maturity. Thus an attitude of prophylaxis is an essential part of geriatric medicine. We can accomplish far more for the aging than we can for the aged. Senility is a consequence of aging. That is where we arrive if we live long enough.

I was asked the other day, "How do you propose to stop aging and growing older?" I said, "The only way is to die young."

Geriatric medicine is not a specialty in the usual sense of the term. Our medical specialties are, as a whole, based on techniques (as for example, medicine versus surgery) or upon anatomical grounds (otolaryngology, obstetrics, ophthalmology, dermatology, et cetera). Geriatrics includes all of the specialities, with the exception of pediatrics and obstetrics. We hope that geriatrics will not become a specialty in any narrow sense. Geriatric medicine should be considered a point of view, or an attitude of mind which takes cognizance of the changes introduced by senescence. We prefer the adjective, "geriatric medicine," to the noun, "geriatrics," because it is descriptive rather than definitive.

Certain basic principles must be recognized. First of all, we must become more fully aware of the fact that to age is to change. There is very close parallelism between geriatrics and pediatrics. Pediatrics did not come into its full vigor until after it was recognized that the child was not just

"a little man," but that the child presents characteristics of his physiology, anatomy, nutrition, immunity, and emotional and intellectual status, which were peculiar to his age. The same concept applies to the other end of the life span. Older people are different people. They are not the same individuals, except in name and legal identity, that they were as young adults. Biologically, intellectually, and emotionally we change day by day, hour by hour. Every one of you are not the same as you were yesterday, and after sitting through today you may be even worse off tomorrow. The rate of change, however, is a very gradual one, and the older we grow the slower are the processes of aging.

The second basic principle which we have to consider in the practice of geriatric medicine is that we have three groups of factors which introduce elements of difference from medicine as a whole: (1) certain characteristics of the older individual; (2) certain characteristics of the diseases that we are confronted with; and (3) certain large gaps of knowledge in medical science and practice. These factors will determine what geriatric medicine may hope to accomplish.

Now I would like to say a few words in regard to some of the significant characteristics of older people. Unfortunately, I have to present this material in somewhat the manner as movie houses do, by "selected shorts." It is utterly impossible to cover the field of geriatric medicine in a single paper with any degree of comprehension.

The first thing to be kept in mind is the variability of the individual. Variability between different people increases with advancing age. There are several obvious reasons for this. First, the asymmetry in the rate of senescence and in the depreciation of age between different individuals and in different parts of the same individual. Second, we must not forget the effects of yesterdays. No two people are ever subject to the same series of injuries, infections, fatigues, intoxications, and physical or emotional traumata in identical sequence or in parallel intensity. No two people live identical lives. Therefore, the scars or consequences of these various insults, which are a part of living, will vary greatly in different individuals. The more yesterdays we have experienced, the greater the variation between different people. The essential clinical significance of this variability is that we must individualize in the care of older patients. To apply routine methods and thinking in either diagnosis or therapy merely invites a high percentage of serious errors.

The changes which take place in senescence are due to two things: the passage of time, or aging per se, and the effects of the various vicissitudes of existence (previous infections, injuries, exhaustions, et cetera). Health is relative. At no age are we perfect with the maximum reserve capacity existent in all our functional abilities. As we acquire years we also acquire a whole sequence of injuries. Each and every insult to the organism of no matter what nature leaves some scarring behind. The older we become, the more these hidden scars accumulate. It is not sensible to assume that an older individual is fully healthy before the onset of an acute illness. This question of preexistent injury is extremely important in diagnosis, because it confuses interpretation of symptoms and signs. Unless we have carefully studied the patient previously, we must ask ourselves, "What part of our clinical findings are due to the present acute illness and what part to previous injuries? How much of it is recent; how much is old?" This situation is in sharp contrast to the diagnostic thinking of the pediatrician who justifiably assumes that a child presenting a group of acute symptoms was relatively well prior to the acute illness, and that therefore all the symptomatology is due to the acute illness. We must take exactly the opposite viewpoint. Furthermore, we must always remember that there can be no sharp line of division between the normal and the abnormal. When does disease begin? It is always there in one sense, for health is never perfect. We must not say, "This man is well and this man is sick." Rather, must we think in terms of relative health and consider one man less healthy than the other.

Another very important aspect of the changes introduced by aging is that with aging there occurs a gradual depreciation in the responses of the organism in maintaining internal equilibrium. For example, maintenance of a normal blood sugar level under conditions of starvation or following ingestion of sugar becomes increasingly less efficient. There are many other equilibria in the state of constant flux. Both the speed and the quantitative capacity to compensate for adverse environmental conditions gradually diminish. From a clinical viewpoint this is most important. It affects diagnosis, treatment, and prognostication. Symptoms are largely responses of the organism to insults. These responses become less and less conspicuous as individuals age. Thus, disease in later years becomes relatively asymptomatic. Pneumonia in the old rarely produces more than a minimal rise of temperature. An acutely inflamed appendix may rupture and lead to fatal peritonitis with only slight subjective discomfort, which the older person may describe as mild gas pains. We must be much more alert for minor complaints than we need to be with younger individuals, where the symptoms of disease are typically florid, conspicuous, and explosive. The silence of symptoms frequently confuses diagnosis. Furthermore, because they feel less violently ill, older people frequently delay seeking medical attention. Thus, their recovery is jeopardized. Many of the clinical phenomena of disease, such as fever, proteinuria, glycosuria, local hyperemia, leukocytosis, and the like are actually useful protective reactions; the lessened response is evidence of lessened resistance. Thus, in one sense diminishing reactivity of the older person is perhaps a blessing, inasmuch as he doesn't suffer so much. On the other hand, it can

be a serious curse if it leads to neglect, hides the true diagnosis, or impairs resistance and compensation to injury.

There are many other facets to geriatric medicine. The older patient has many significant characteristics which we cannot consider now. But I should like to stress the necessity for greater time for repair during convalescence. The less active homeostatic mechanisms also slow the reparative process. There is no substitute for time. It is pragmatic to assume that for each five years we have lived it takes us an additional twenty-four hours to recover from any specific injury. Thus, repair that required but two days in a boy of five will demand twenty-four days in a man of sixty.

I merely wish to touch upon the mental changes. They were discussed by someone else as far as abnormalities were concerned. The normal changes include fixation of ideas, a little slowing of the mental pick-up, and failing memory, especially for recent events. However, mentally aging is not all decline. There are compensatory changes in our intellect and in our emotional equanimity. A truly mature individual, one that is emotionally mature as well as intellectually grown up, is uniquely precious. Although our speed of reaction may lessen with age, our judgment tends to become stronger, assuming we have exercised it, but not if we do not use it, however. Disuse makes for atrophy; continued use encourages hypertrophy and vigor. I am perfectly willing to make a wager that the ability to learn, as measured by the rate of learning, will depreciate more in four years in an individual who does no learning during those four years than it will in forty years in an individual who continues to study during the whole of the period. I shall be profoundly surprised if our universities do not discover that veterans returning to school after a lapse of years without intellectual exercise have suffered serious depreciation in their ability to learn. This depreciation from interruption of study is not a question of age change, but of the effects of use and disuse. The old dictum that "you can't teach an old dog new tricks" has done immeasurable harm. It is not true. The falsehood has been perpetuated and nourished by three groups: (1) By the aged themselves, because it serves as an excuse for indolence. They say, "I am too old to learn; therefore I do not have to make the effort." (2) Youth, always cocksure and jealous of older individuals. (3) The erroneous concept is perpetuated by those who have attempted to teach the old dog new tricks and failed because they forgot that in order to be successful they must know more than the dog. We *can* teach an old dog new tricks if he wants to learn.

What about the characteristics of the diseases common among older individuals? There are no specific diseases limited in their occurrence to the later years of life. Certain so-called "degenerative disorders" are definitely more frequent and much more significant. However, they may occur at any age. The most important are the cardiovascular-renal group, arteriosclerosis, hypertensive arterial disease, coronary insufficiency, and metabolic disorders, diabetes mellitus, the climacteric, gout, arthritis, and cancer. These are the major hazards to healthy longevity.

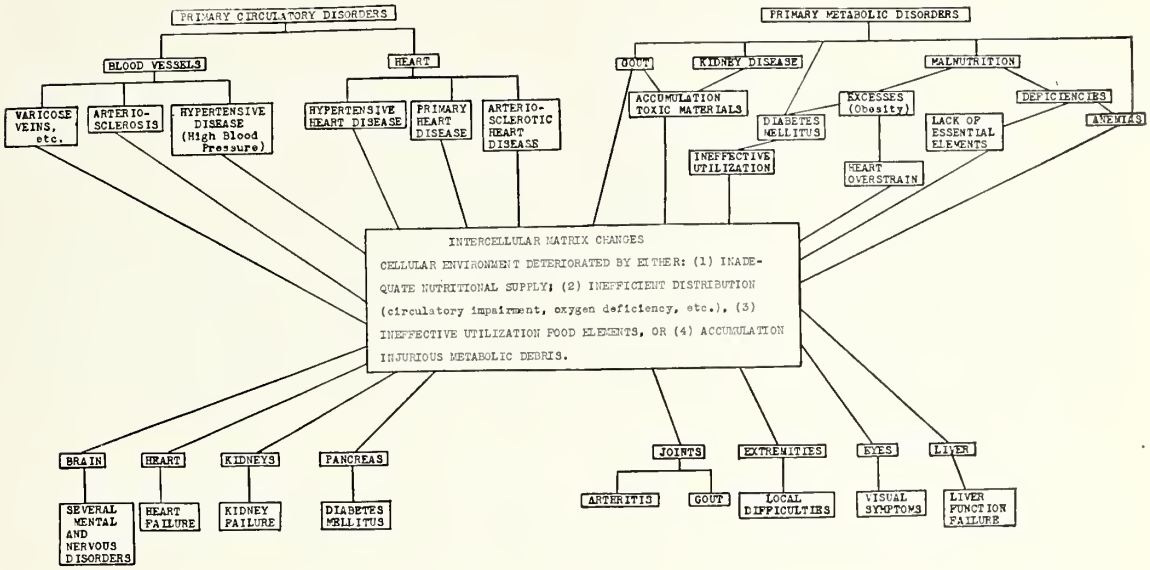
In connection with the relative importance of these various disorders, I should like to report the results of a study made by Dr. Henry Simms, of Columbia University, of the amount of money spent in medical research in 1940, including both public and private moneys. In 1940, for every death due to infectious diseases, approximately six dollars was spent on research of infectious diseases; for every death due to cancer, two dollars was spent on research on cancer and allied problems; for every death due to poliomyelitis in 1940, five hundred dollars was spent on research of infantile paralysis; and for every death due to cardiovascular disease, seventeen cents was spent in the study of these disorders. This deplorable distribution is obviously due to emotional and political motivations. Logical distribution calls for appreciation of the relative importance of the many problems. It is time we revamped our appeals for drives and funds and informed the public of the true state of affairs.

The diseases which are the most common in later years differ very greatly from those commonly seen in youth. In youth the causes of diseases arise almost entirely from without: infections, traumata, and burns. The etiology is usually relatively obvious, and on the whole it is specific and recent. In contrast, the causation of the so-called "degenerative diseases" is essentially endogenous, very obscure, cumulative, and multiple, with many superimposed factors, and often dating back long into the past of the individual. The ancient fable that it was the last straw that broke the camel's back is an apt simile. But we must remember not to focus all our attention on the last straw alone.

All the straws that preceded that last one are equally important. The last straw would have been insignificant had it not been for all these preceding it. Furthermore, the preceding insults may not have been straws at all, but hay or bricks, or kegs of wine. Etiology is always multiple and frequently most obscure. This is a major obstacle to full understanding, and therefore effective preventive and curative treatment of the progressive disorders of later years.

In youth the beginnings of disease are conspicuous and abrupt. The onset of the degenerative disorders are insidious. These illnesses sneak up on us. They don't ring a bell or wave a red flag. Chronic progressive diseases are silent saboteurs. They bore from within, usually without symptoms until irrevocable damage is done. In youth the course of disease is usually acute and frequently produces immunity. In contradistinction, the course of degenerative disorders is chronic and inevitably progressive, with a long disability prior to death, inducing no protective immunity, but

FIGURE I



rather increasing vulnerability to other diseases. Lastly, in contrasting these two groups of diseases, the acute disorders display much less variation in symptomatology and course between different cases than is presented by the chronic illnesses of later years.

Some of the implications of these contrasting characteristics are worthy of emphasis. In the first place, these degenerative disorders overlap. Refinement of diagnostic methods and nosographic classification have led medical science to make some arbitrary diagnostic divisions between certain of the degenerative disorders, which become absurd when we see how interrelated they are. (See Figure I.)

On the one hand, we have a group of related disorders involving the circulation; on the other, metabolic defects. Their intimate interdependence is revealed in the chart. It is most significant that every one of these disturbances of health is essentially a nutritional disorder. They all affect the cellular nutrition through interference with proper functioning of the intercellular matrix. They cause damage by inducing: (1) inadequacy of nutritional supply; (2) insufficiency of nutritional distribution, as in cardiac failure or in circulatory inadequacy; (3) ineffective utilization of nutriments, as in diabetes mellitus; or lastly, (4) accumulation of waste products of metabolism in the intercellular matrix. Although we are apt to speak glibly of specific disorders, such as diabetes mellitus, coronary occlusion, or chronic nephritis, often the actual pathogenesis is that of a generalized arteriosclerosis, with predominating injury in some parenchymatous organ. If impairment is greatest in the cerebral vessels we are prone to call the condition arteriosclerotic or senile dementia; if the damage predominates in the coronary arteries the disorder is classified as heart disease; if the pancreatic tissues are starved and intoxicated by interference with their nutrition, diabetes mellitus results. Yet, fundamentally, the problem is a single, broad, basic one—impairment of tissue nutrition. The symptoms will depend upon which tissues are most severely hurt, but such variation does not warrant the habitual over-refinement in diagnosis so common today.

If we could only get rid of the singular of the term "cause." Nothing arises from a single cause; not even simple things like marriage, divorce, or war, let alone disease. There are always many causes. The postulates and developments of bacteriology, immensely important as they were, have also done a lot of harm, because they have overemphasized the idea of specific etiology, the single cause. We must learn to think of all the facets of etiology and remember that the seed requires both soil and sun and moisture. Knowledge of causation is the essence of good medicine. We cannot expect to develop effective curative or preventive treatment unless we understand causation. Causation can be analyzed. Invariably there are three groups of factors. Years ago, when I was lecturing to medical students, I kept drilling them about "the three P's"—the predisposing, provoking, and the perpetuating factors. This analytic grouping of causative influences is not limited to medicine alone. Whatever happens, it happens because there are predisposing, provoking, and perpetuating factors. Anybody who sets out to find "the cause" for hypertensive disease will fail, for there are many factors and in no two instances is the combination of etiologic elements necessarily the same.

Another important characteristic of the disorders common in later maturity is their progressive nature. Usually the mature patient with hypertensive disease, diabetes mellitus, or arthritis

is in no immediate jeopardy, but these disorders tend to progress with what is almost diabolical inevitableness. Lasting spontaneous improvement is almost unknown. Frequently the best that therapy has to offer is arrest of progression. At present we can hope only to control these disorders, not to cure them. This is true largely because we do not yet fully understand their causation.

Because of their insidious and asymptomatic onset, we frequently do not discover these degenerative disorders early enough to be truly useful to the patient. We must learn to look for them. If we wait until symptoms are so far advanced that the patient reports because he feels miserable we will be too late to accomplish much more than palliation. From the very beginning of our medical and premedical education, every physician has been trained to look for disease. Thus, it is inevitable that we think in terms of disease. We must learn to think in terms of health. Our medical students must learn that health is relative. The medical dictionaries of today are still so antiquated that they define health as, "That state of being in the absence of disease." Such a negativistic definition is dangerous and deadening. It is like saying that the sane individual is an individual who is not insane. Health is hard to define, and harder yet to measure. Health is essentially an ideal, an abstraction. In reality it will always be found to be relative. Let us attempt a definition, if only for purposes of starting an argument. Health is that state of being in which all our many reserve capacities are at their maximum. Although perfect health may be unattainable, it can be approached. As physicians we must remember there is always room for improvement.

Geriatric medicine can advance to its ultimate accomplishments only after we have learned how to measure health and appreciate the importance of constructing greater health in those relatively impaired but not obviously diseased. Diagnosis should be more than the discovering and naming of disease entities. Health mensuration requires the ability to appreciate the significance of subtle clews. There are many variables to be considered. A complete change in attitude is necessary. Medical science will have to develop more clinical techniques to reveal early functional depreciations. This means the development of physiologic stress tests, because we cannot measure reserves except under conditions of stress.

What does the future hold? The future of geriatric medicine is what we make it. It holds the promise of health construction for adults. With better treatment of disease and an active program for the construction of health, we can hope to start the second forty years of life with far more vigor and assurance than is now possible. As pediatricians have done with children, so can we do with adults. The treatment of disease attempts to reconstruct health. Treatment of the apparently well constructs greater health. The objectives of geriatric medicine are not just increased longevity, but increased health and vigor. The approach is through periodic health consultations. If our sole objective is preventive medicine, we will fail. Prevention has no emotional appeal. The only way we can prove the benefits of prevention per se is by statistics, and statistics do not initiate effort. They are too impersonal. However, if we tell individuals we will try to raise their own health to a higher level, the advantages are personal and immediate.

The immense human inertia to the concept of prevention (which is not limited to medicine) can be largely overcome if we take as our text the construction of health rather than the prevention of specific diseases. For example, suppose we have an individual who though superficially well is moderately anemic, with a hemoglobin 80 per cent of what it should be. Most people will say that such levels are average and let it go at that. But if we refuse to be satisfied with average and seek to attain the optimum, treating this patient to raise his hemoglobin content to 100 per cent, the odds are ten to one that the patient will return and will say, "I didn't realize that it wasn't normal to feel tired as I formerly did." We must cease confusing average with optimum and strive to attain the best health possible.

The importance and techniques of a proper health inventory is a subject too immense for discussion now. It is worthy of a whole series of lectures. It requires time and skill, and therefore money. The health consultation differs fundamentally from the preventive concepts of public health in that the initiative and the effort have to be taken and made by the patient and because it must be highly individualistic. Health construction has to be sought. The passive role of the beneficiary to the benefits of public health is one of the reasons why it has been extraordinarily effective in controlling exogenous and infective disease. Clean water, clean food, et cetera, are obtained by all of us without effort on our part. The chronic progressive disorders of later years will not be prevented in such manner. The patient must exert himself on his own behalf. He must take the initiative. His health is his own responsibility. Medicine can only guide him. It cannot be expected to also supply the motive force. This can be developed only by education. In the classroom, in the pulpit, and in the press we can and should reiterate constantly the message that health maintenance is an individual and personal responsibility. It is my opinion that the great majority of degenerative disorders are self-induced, because of ignorance. The ignorance is not limited to our patients. Medical science is still ignorant of the causation of these disorders, and therefore clinicians can not be expected to know how to prevent them. Ultimately we may learn how to prevent these serious progressive disorders. In the meantime sufficient knowledge does exist to permit wiser living than is generally practiced. Let us use the tools we have while searching for better ones. No

system will ever be able to *give* health to anyone. Health is not a right, it is a privilege. As a privilege, health entails the responsibility for its maintenance.

In closing, I want to emphasize that these remarks have presented a very sketchy and incomplete picture of the problems of geriatric medicine. Longevity of the population is here today, and will continue to increase. Our present longevity is associated with a vast load of disability and dependency because of chronic and progressive disease. This burden is increasing. Longevity without health is a social, economic, and personal disaster. Longevity with health has immense potentialities. We do not yet know what all the potentialities are because the elderly have not yet had their chance. They constitute an immense, untapped reservoir of accomplishment. It is only mature individuals who can reveal the full potentialities of man himself. Life has depth and breadth, as well as length. Our objective should be to add life to the years, not merely years to existence. Mental and physical health can be conserved and augmented in maturity as well as in infancy and youth. If we succeed, it means that more men and women will live long enough, deep enough, and wide enough to think. Such maturity of the peoples of the world might lead to lasting peace. This goal is worthy of our best and most strenuous efforts. I would suggest that the time to start working on better health in later maturity is *now*.

MENTAL HYGIENE IN GERIATRICS*

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INDIANAPOLIS

There is no field of medicine that has felt the impact of geriatrics as much as the field of psychiatry. It is natural to expect a certain amount of mental as well as physical decline in the people growing older, and particularly in those above sixty-five years of age. Such things as failing of recent memory—the person forgetting where he laid his glasses; the retention of remote memory with reminiscence; the getting more "set in his ways," even to the point of stubbornness; and mild impairment of judgment and reasoning are all considered normal. The question then arises, how much decline or impairment of the mental faculties can we consider as the normal aging process? Further, at what point in this decline or impairment should people be considered as mentally sick, and their care and treatment take on the characteristics of a therapeutic approach psychiatrically? These questions defy answers at the present time.

The programs of the public health departments in improving conditions for more healthy living; the program of the pediatrician in practicing preventive medicine in children since the turn of the century; and the various safety campaigns being promoted and carried on have worked wonders in the extension of the average age of life expectancy at birth in the last fifty years. It has been only in the last few years that a very few physicians have begun to consider the problem of aging.

In psychiatry this impact has made itself felt by the great increase in the number of patients being committed to our state hospitals, and for which facilities for their study, treatment, and care are inadequate. The statistics in relation to the available facilities are extremely interesting and thought-provoking.

Reference to Table I shows that in the twenty-two-year period from 1923 to 1945 there has been a 150 per cent increase in admissions to our state hospitals sixty years and over, and a 116 per cent increase in resident patients of the same age group.

TABLE I

	1923	*1945*	*Percentage Increase*
First admissions, sixty years and over, to Indiana mental hospitals..	223	558	150%
Patients present, sixty years and over, in Indiana mental hospitals..	1420	3077	116%

The Indiana Council for Mental Health recently conducted a survey in Indiana to try to determine the number of senile mental cases for whom there are no institutional facilities available. The results of this survey tend to show that there is a possible potential load of 1,763 senile mental cases. Of this number, approximately five hundred should have institutional care, as their condition is such that care for them is extremely difficult outside of an institution. If these cases increase proportionately in the same ratio as the population above sixty-five is estimated to increase by 1980, at that time there would be an estimated 4,300 senile mental cases, of whom roughly 1,200 should have institutional care. It is to be pointed out that these figures are only estimates, but from past experience they might be even too low. It is to be further pointed out that these statistics represent a group in our state for which there is no provision for

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institutional care at the present time. They are in addition to the cases represented in the table above.

Since the state hospitals have not been able to keep pace with the problem and build sufficiently to absorb all those cases which are committed, there is a damming back into the communities of these cases, with the communities meeting this problem face to face. With this large number in the communities the problem is forcing itself upon the family physicians, social workers, and public officials. As yet there is no clear solution of the problem. The family physician considers it an annoying problem since there is so little that can be accomplished in treating them. Further, he has had practically no training in geriatrics and has probably seen only a title or two of articles on geriatrics in the medical literature, which he has not taken time to read since he has not been interested in it. It is time for more members of the medical profession to tackle the problem, before the social workers and other officials tackle it. The medical profession can furnish much technical and detailed information that should be considered in meeting it.

There is one question that is rather confusing at this time in relation to senile cases. This is the question: are these cases really cases of mental illness or insanity? One will frequently hear many of the laity and some of the profession say that they are just senile and not insane, which is almost the same as saying that they are not cases of mental illness. For the sake of clarity, let us review what is meant by insanity. Insanity is a legal term; the finding of a court of competent jurisdiction under the law, this finding being made for people whose behavior is such that society can no longer tolerate them. Practically all, but not all, of the cases that are found insane by a court do have a psychosis or mental illness that is the cause of the abnormal behavior of which society is trying to rid itself. However, it must be pointed out that certain cases of psychopathic personality without psychosis are committed by courts because their behavior is such that society can no longer tolerate them. From this then it can be seen that a finding of insanity by a court is not always absolute evidence that the person found insane is suffering from a mental illness or psychosis. Everyone readily accepts a finding of insanity or mental illness in a younger individual whose sensorium shows various and sundry defects, such as emotional irritability, delusions, memory defects, and mild disorientation, regardless of the cause whether it is a bacterial organism or unknown as in the cases of dementia praecox. Then, why should the same sensorium defects of emotional irritability, delusions, memory defects, disorientation, etc., in a person of advanced years be dismissed as just senile? In the latter case there is a general conception, poorly understood, that the process of aging which is not abnormal is the cause for the mental symptoms, therefore the mental symptoms should be normal and the patient just senile. It is the opinion of this writer that these cases in the aged, showing these sensorium defects, are suffering from a mental illness, just the same as a younger person who shows similar sensorium defects. Further, that in those cases where the mental illness is the basis of a behaviour pattern that is intolerable to society, that they can justly be committed by a court just the same as the younger patient. Further, that these cases do rightfully fall within the province of the psychiatrist, and that psychiatry should spend more thought and energy on studying the problem and trying to arrive at a better solution. However, it is strongly pointed out here that the writer is not at all in sympathy with those who attempt to commit mild cases just to get rid of the patients, so the children can keep up with their social engagements, or for the convenience of not having to care for them.

While numerous studies and observations have been made over a number of years on various isolated pathologic conditions of the nervous system, it is only in the last few years that these isolated studies have been collected and correlated and considered as a whole from the perspective viewpoint of geriatrics. Critchley[1] points out that the pathogenicity of old age remains a subject of controversy. There are certain authorities who view the aging process as inevitable and essentially physiologic, while other authorities believe that old age is a disease. While the pathologists have not as yet arrived at a conclusion, it is logical then for the clinicians and psychiatrists to be in some confusion regarding the subject. The attitude of the clinicians is carried over to the laity who jump to the conclusion that these cases are just senile.

It might be well to review some of the more salient findings of pathology in this process, whether physiologic or pathologic. The meninges are usually thickened, and may be adherent to the skull. There may be calcification of the meninges. The brain shows generalized atrophy, being smaller than the normal adult brain. Thewlis[2] quotes Nascher who felt that there was about one-hundred grams loss of weight of the brain in advanced age. With this generalized atrophy the convolutions are shrunken and smaller, with a resultant widening of the sulci. This atrophy appears to be more particularly noted in the frontal region, next in the occipital region, and the writer has seen a few cases where it was noted in the temporal regions. This is due to atrophy and degeneration of the neurones and their replacement by the non-functioning neuroglial cells. The ventricles show various degrees of dilatation. Microscopically, there is atrophy of the neurones, with proliferation of the neuroglia. There are various deposits through the substance of both the gray and the white matter, such as amyloid deposits, and free iron. Senile

[1] Critchley, M.: *Problems of Aging,* Cowdry, W. V., 2nd Ed., Williams & Wilkins Co., 1942.

[2] Thewlis, M. W.: *The Care of the Aged,* C. V. Mosby Co., 1946.

plaques, which consist of annular or stellate argentophil formations, are found scattered throughout the cerebral regions. Although these senile plaques are commonly present, they are not pathognomonic of senility. Changes in the blood vessels of an involutional type, such as hyaline infiltration, thickening of the media, and intima, are found.

The personality reaches its psychological maturity between adolescence and the beginning of senescence, which is roughly in the twenties and thirties. At this time the personality is more stable, less self-conscious and more self-confident. This is without doubt due to a well-stabilized functioning of the physiologic mechanisms of the body.

The transition or change from this well-stabilized psychologic maturity of the personality, to the psychologic declining of the personality due to aging, starts at various ages. Hamilton[3] cites Havelock Ellis (1933) who prefers to call this the "critical age" and who states: "The biological foundation (of the critical age in males) is genital decadence with changed neuroendocrine reactions. Kenneth Walker would place the age of this change at about fifty-five to sixty, Rankin between fifty-seven and sixty-three, Max Marcuse between forty-five and fifty-five and even at forty. I would say that in many cases such a period occurs even near the age of thirty-eight." Hamilton in his own highly-selected group of cases found the age to be from thirty-seven to forty.

At this age there is a beginning failure of sexual potency or vigor. Also there is a weakening of the ego or reality principle which tends to allow the primitive and instinctive forces of the id or pleasure-principle to determine more of the actions of the personality. With the beginning of failure of sexual potency and vigor there is engendered fear of impotence into the subconscious mind. Being goaded by this fear and suffering from a weakening of the ego, the male quite frequently steps outside the matrimonial ties in an attempt to prove to himself that he is still potent. He uses his mechanism of compensation to justify the extramarital experience as proof that he is still potent. Following this he uses the mechanism of projection to project his own failing potency onto his marital partner. These mechanisms form the basis for the action, not only of males but in some instances of females, in many of the cases who shock their friends and the community and add grist to the mill of the gossips by their extramarital experiences.

As the aging process continues into the fifties, sixties, and seventies, with the progressive weakening of the ego in certain cases, there is the allowing of the primitive and instinctive forces of the id to more and more dominate the personality. This then accounts for the situation occasionally encountered where a dignified, highly-respected and reputable old gentleman loses his control and plays with the genital organs of young children. When the old gentleman is questioned he does not know why he has done it, and he is sincere in his statements. If the case is brought to the attention of the legal profession they are equally perplexed over the situation.

Wechsler[4] shows first that intellectual ability as a whole follows the same general decline as does physical ability; second, that the individual abilities which enter into general intelligence must of necessity partake of this decline, although at different rates. He further reports that general comprehension and information hold up rather well, whereas rote memory and sheer learning decline very markedly with age, and that general verbal abilities hold up much better than non-verbal abilities.

As the aging person grows older, his friends die off so that he comes to have a feeling of loneliness, since he does not make new friends easily. Along with this, the physical decline impresses on him his inability as a wage earner, with its resultant hampering of his financial status, with the further possibility of financial dependence upon children, friends, or others. Following the termination of financial productivity, if there is not sufficient finances saved up for financial independence and security the aged person then must live with his children, friends, or others. These feelings of loneliness and insecurity have a marked effect upon the personality of the aging person.

Under present-day housing conditions where the children live in small houses or apartments, problems are created for both the old folks and the children. For the old folks there is the development of ideas of insecurity, being in the way, not being wanted, being a burden to the children or a bother to others, dissatisfaction with the way the children manage their household and finances, *ad infinitum*, all of which tend to lead to anxiety states on the part of the old folks. For the children, the old folks hamper the children's activities, make themselves generally troublesome, are never satisfied with the care which the children are providing for them, et cetera. If the aging person has some funds still available, the children fear (possibly with ulterior motives) that the funds will not hold out to care for the aging person, and that the children will not have the money to finish providing for the old folks. All of these factors on the part of the children lead to anxieties. From these anxieties, increasing in intensity on both sides, the conflict becomes greater and greater. Due to the fact that there has been a decline in the control of the personality of the aging person in such fields as emotional instability and judgment, the old folks are the first to crack under the strain and exhibit outbursts of emotion, possibly both physical and verbal. The conflict is

[3] Hamilton, G. V.: *Problems of Aging*, Cowdry, E. V., 2nd Ed., Williams & Wilkins Co., (p. 821) 1942.

[4] Wechsler, David: *Intellectual Changes with Age; Mental Health in Later Maturity*, Supplement No. 148, to Public Health Reports, (p. 43) 1941.

then resolved by calling in the family physician and starting the process of commitment, with the aging person eventually being sent to the state hospital. The children are relieved of a burden, both financial and psychological. The aged person in a short time after admission to the state hospital, where he has been removed from the conflict with the family so that his anxieties can be reduced, receiving his meals, sleep and rest regularly, becomes one of the many docile, quiet, pleasant seniles which are so increasing in number in the state hospitals. While the foregoing may sound exaggerated, a review of the statistics previously quoted tends to make one feel that it is not too exaggerated. Fortunate, indeed, is the aged person who has several children with whom he can make his home. As the anxieties and conflicts arise in one home, he can move to the home of another of the children. There the aged person can gain a sympathetic ear for a while at least, and free himself of the conditions leading to the anxieties developed in the last home. When the conflict arises in this home, the aged person can then move to the home of another. Thus, having opportunities to free himself occasionally, the aged person has a better opportunity of preventing the conflict reaching the height of outbursts with aggressive actions, with its resultant trip to the state hospital.

In some cases where there is financial security and independence, the feeling sometimes develops that relatives and others are just waiting for the day when the resources will be divided. These individuals develop a suspicious and paranoid character to many of their personality manifestations and actions.

It is felt that the type of personality in adult maturity has much to do with the type of psychological or mental reaction which the aging person will present. This in turn will play an important part in the approach which one makes to these problems.

Probably one of the most important factors in the mental hygiene of aging is that of insecurity. Insecurity leads to many personality manifestations throughout life. It is readily seen then that insecurity in the aged person with the prospects of physical incapacities can lead to fears and anxieties: fear as to what is to become of them; whether they will be able to get someone to care for them, et cetera. There is little that the physician can do regarding security except to help place the aging person with some agency which can help provide some degree of security. Some authorities have advocated a broadening of the Social Security Program as a means of providing security for these aging people.

Development of interests in the aging person is important. The greater the number of interests which the individual had in early life, the easier it is to find some subject upon which to develop his interest when aged. There is no better way for the physician to lead the aged person to develop an interest in things other than his own plight than to do a thorough history, physical examination, mental examination, and explore the emotional factors and examine the family relationships; then take time to explain the patient's condition to him. This interest on the part of the physician will be reciprocated on the part of the patient. Listening to the aging person tell his difficulties and troubles, time-consuming and boring as they may be, will elicit the patient's interest. The writer recalls the formation of an excellent friendship by patiently listening for more than two hours to an eighty-two-year-old describe his operation with a most unusual number of superlative adjectives. With the development of interest on the part of the aging person, the physician can then direct the aging person's attention to various and sundry projects of occupational therapy. Wherever possible these occupational-therapy projects should have a real value. Doing useless occupational therapeutic projects just to provide some physical activity with the hands and arms usually only adds to the feeling of uselessness. The higher the value of the product, the more will be the feeling of accomplishment on the part of the aging person.

One should strive to develop in the aging person a sense of hope, confidence in himself, and a philosophy of life that includes serenity and cheerfulness. Aging persons, usually being quite set in their ways, are not very susceptible to direct suggestion. They are usually more susceptible to indirect suggestion and encouragement. For instance, one will usually accomplish more by calling their attention to the more serious plight of acquaintances and then encouraging them regarding their own condition. The conversation with aging persons should be carefully watched so that it will be constructive and encouraging. If at all possible, the aging person should be in an environment where he can express as much of a degree of independence as his situation will permit. He should be encouraged to do things worth while, for the gratification of accomplishment will help overcome the feeling of uselessness. Conflicts should be kept at a minimum, and there should be an atmosphere of affection and approval.

Over-protection of the aging person by attentive children leads to as many difficulties as over-protection of young children by doting parents. It has been frequently observed that the children are constantly advising, admonishing, or begging the aging person not to do physical activities which he has been accustomed to doing. If the person accedes to these wishes, he is usually unhappy in doing so. He feels suppressed and deprived of the feelings of gratification of accomplishment that comes with doing. This unhappiness will be expressed by various emotional reactions with their resultant conflicts. One cannot change lifetime habit patterns over night, such as a lifetime of activity being retired suddenly into idleness, without dire consequences. Examples of this may be seen in every field of endeavor in men who die

soon after retirement, whether that retirement be compulsory or voluntary. It would appear wise to allow, or even advise, the aging person to continue performing as many of his usual physical and mental activities as he can. He will be much happier, and will make a better adjustment to life even if he does "die with his boots on."

In the handling of these problems of the aging person, the wisdom of Solomon could be tried and probably found wanting. It is felt that this paper will be worth while if it can point out some of the many facets of the mental hygiene problem of aging, and how much further study is needed looking toward a solution of the problem.

ARTHRITIS*

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In today's discussion on geriatrics we are interested in hypertrophic arthritis because it is the arthritis of advancing years. Degenerative arthritis and osteo-arthritis are synonymous terms.

Yater has given a simple definition and description of the disease: "Hypertrophic arthritis is a chronic disease of many joints, occurring mainly after the age of forty, and characterized particularly by an overgrowth of bone at the articular surfaces. It is not associated with infection and does not produce ankylosis. This disease occurs almost as commonly as arteriosclerosis; and in many cases, like arteriosclerosis, it is asymptomatic. It is astounding how often evidence of hypertrophic arthritis is found in x-ray plates taken for other purposes, although the changes have evoked no symptoms. Many advanced cases of hypertrophic arthritis are symptom-free, especially if non-weight-bearing joints are not involved.

Hypertrophic arthritis does occasionally occur before the age of forty. In a large series of cases, however, the highest incidence occurred between fifty-five and sixty-five years of age.

The etiology of hypertrophic arthritis is not specific. Metabolic changes of age are important factors in the etiology.

The trauma of long usage, that is, common everyday wear and tear and the trauma of faulty posture which accompany aging of the body, play an important part in the etiology. The short, stocky individuals are more susceptible to this disease. They usually are obese or have that tendency. They are heavy eaters and frequently have a sluggish gastro-intestinal tract. They are likely to be very active individuals, and may be active to the extent that fatigue plays a part in the production of the symptoms. The disease occurs slightly more frequently in the male than in the female.

There is a definite hereditary factor in hypertrophic arthritis. Various series have shown forty-seven to fifty-five of the cases with a definite family history of the disease. Climate seems to have little effect on the development of the disease. It is found in the tropical climates as well as in the cold climates. However, exposure to cold and moisture may cause an increase in the symptoms. Approximately 25 to 30 per cent of all arthritis is of the hypertrophic type.

As to the role of infection in hypertrophic arthritis, there is some difference of opinion. The majority, however, believe that infection plays a minor part in the disease. Certainly the sedimentation rate is seldom elevated either in the advanced or the acute stages of the disease.

Any joint in the body may be involved with this type of arthritis. Frequently only one large joint is involved, a weight-bearing joint, and usually the knee or the hip. Involvement of both knees alone is common, and one is usually much more advanced than the other. The small joints of the hands and feet are frequently involved. The knuckles become swollen and knobby; deformity of the hand develops; and Heberden's nodes are usually present. These are small, bony outgrowths at the sides of the terminal phalangeal joints. In the early stages the node is a soft nodule containing mucoid material and arises as a result of degeneration of the periarticular soft tissue, with subsequent ossification.

Hypertrophic arthritis is a degeneration of articular cartilage and bone. Both the cells and the matrix of the cartilage degenerate, and the smooth surface becomes roughened. The cartilage cells swell, burst, and disappear, and the matrix undergoes a perpendicular fibrillation. The softened cartilage is gradually worn away until the underlying bone is exposed. The progress is uneven and the joint becomes very irregular. The periphery of the cartilage has a much better blood supply than the central part, and survives. There is some degeneration of the bone with the cartilage, but the portion of the bone that becomes exposed undergoes a process of condensation and hardening, and as a result becomes like polished ivory. Due to the condensed layer, areas of degeneration and rarefaction occur. In addition to the central atrophy there is a

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peripheral proliferation where the blood supply is better. Cartilaginous spurs and lipping occur at the margins of the articular cartilage. They increase the joint surface and may be compensatory in nature. They become ossified, and osteophytes are formed farther out so that the joint surface is surrounded by a rim of new growth which greatly limits the motion of the joint. The synovial membrane becomes fibrous and fatty and presents shaggy fringes which may be changed into cartilage, and which become detached to form joint mice.

The onset of hypertrophic arthritis is gradual. One group may be characterized by involvement of the hands. The distal interphalangeal joints are usually involved first. The first evidence may be unusual pain on striking the knuckles. General tenderness may be a late development, or may never be more than mild.

The knee is a site of involvement of almost equal frequency with the fingers, but it is always a much more serious condition.

Involvement of the fingers may be ignored for years, but the same involvement in the knee usually causes the patient to seek early relief. The knee is a weight-bearing joint, and it is probable that early manifestation of the disease in this joint is aggravated by the trauma of use. The frequency of involvement of the knee may be referable to the same cause.

The earliest subjective symptom is usually stiffness after sitting, although there may be more or less pain upon weight-bearing and upon motion from the beginning.

There is fairly early tenderness to pressure along the joint margins, especially the medial side of the knee. Pain and puffiness at the lower end of the patella soon develop. Effusion may develop, but usually does not occur until late, if ever.

The earliest x-ray findings are usually spurs at the upper and lower end of the patella. Next occurs sharpening, then overgrowth of the edges of the condyles of the femur and tibia.

Stiffness and disability at this stage cannot be explained on the basis of cartilaginous or bony changes, and the joint surfaces are mechanically entirely adequate for function. The capsule of the joint, and more especially the tendenous and ligamentous structures, are the subject of thickening, adhesions, diminution of elasticity, and a tendency toward contracture. There usually is a marked crepitus to palpation. Deformities develop very slowly, and, as stated before, complete ankylosis seldom occurs.

There are no general symptoms of the disease, only the joint symptoms. The blood count, blood chemistry, sedimentation rate, and temperature are unaffected.

Treatment of hypertrophic arthritis is both general and local. There is no specific treatment. As to general treatment, weight reduction is used if necessary, together with correction of diet. Vaccines and colloidal gold are of no value. Removal of foci of infection is advisable, not expecting joint relief but to raise the patient's resistance to the highest level.

Much has been written about the value of high doses of Vitamin D. I believe it has some value if used over a long period. A.S.A. is used for relief of pain.

Graded amounts of exercise and activity are of value. Some patients must be slowed down some; some must be made to exercise. The patient must learn his limitations and live within them.

Local treatment to the joints is valuable, such as heat, diathermy or baking, and massage and active exercise of specific joint.

X-ray therapy is of considerable value to swollen painful joints in the earlier stages.

Surgical treatment for removal of spurs or fusion of a joint are sometimes necessary.

Hypertrophic arthritis is a disease of old age. It is more than that: it is part of old age. To prevent it or to lessen it, we must not study its prevention or treatment specifically. We must study the cause of degenerative old age.

NATIONAL HEARING WEEK—NOVEMBER 10-16

The week of November 10-16 has been set aside as the National Hearing Week, according to an announcement by Dr. C. Stewart Nash, president of the American Hearing Society, Washington, D.C.

"Authorities estimate that one out of every ten persons in America has a hearing loss, ranging from a slight loss to almost total deafness. The social and mental effects of this hearing loss can do much to warp the personality of a growing child, and in addition may prove an effective bar to the child's making a success of later life," said Dr. Nash. He went on to point out the necessity for parents and teachers to watch children carefully for any signs of hearing loss, especially after illnesses involving the nasal passages, ears, or throat.

While the American Hearing Society places major emphasis on its prevention campaign, it also recognizes the need to conserve the remaining hearing of those with existing impairments and to rehabilitate those handicapped by hearing losses to a normal life of economic and social activity.

CANCER*

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One out of six individuals die of cancer. Last year cancer ranked third as a cause of death in Indiana. Heart disease leads with 10,000 deaths, or a rate of 318 per 100,000. Apoplexy actually bears a close relation and is listed in second place, while cancer ranks third. Cancer ranks far above accidents, kidney disease, pneumonia, or tuberculosis. Infantile paralysis stands at the bottom of our abbreviated scale. Grouped by age, cancer deaths in Indiana in 1945 showed but 136 in the age group under thirty-five, while there were 280 in the thirty-five to forty-five year age group, 615 in the forty-five to fifty-five year group, 1,132 in the fifty-five to sixty-five year group, 1,296 in the sixty-five to seventy-five year group, and 1,244 in the group above seventy-five. Women are in slightly greater danger of dying from cancer than men.

What is cancer? The answer is that cancer is "life." It is living tissue. It is an abnormal living tissue. Paradoxically, cancer is human flesh itself. It continues to live, sapping vitality until it actually exhausts and kills the very life which sustains it. At present about one in three cancer patients can be saved. Let us consider the regions where cancer affects the human body. The digestive tract, which includes the stomach, bowel, and rectum, tops the list. Subsequently in order are the uterus, the breast, the genitalia, the respiratory system, the urinary organs, and last, the mouth and lip. Now, let us consider these growths more closely. Cancer of the stomach accounts for one-half of the cancer cases occurring in men, and one-third the cancer cases occurring in women. It is distributed throughout the entire adult age group, but is most prevalent in persons over forty. Here is a kodacrome of a stomach opened to show the cancer. (Kodachromes illustrating lesions were projected.) Note the thickness and abnormal character of the growth. When properly prepared under the microscope it shows gland-like structures which bear some resemblance to normal stomach glands, but which continue to grow uncontrolled throughout the stomach wall. These look alike in various areas as is shown in another slide from the same growth. The picture varies slightly, although similar, and these glands usually can be easily identified. Occasionally scarring obscures the gland-like growth, and nature thus attempts to control the spread of the cancer.

Cancer of the bowel is a disease of later life. The symptom usually given is that of an alternating constipation and diarrhea. The presence of blood in the stool, although common in such conditions as piles or hemorrhoids, may indicate cancer and should be investigated. (Kodachromes projected.) This first kodachrome shows a small mass growing and pushing out into the large bowel. Such a mass becomes a cauliflower-like, friable growth which breaks down or forms an ulcerating lesion. At the same time such a growth tends to grow into the bowel wall, thus cutting down on the size of the lumen. If an intestine such as this is cut in half longitudinally, the constricting effect of the cancer is better illustrated. This kodachrome shows a different lesion accomplishing somewhat the same type of change and illustrates how the caliber is reduced until an absolute obstruction occurs.

Next in order of frequency is cancer of the uterus. One-fourth of all the cancer in women involve the uterus. It is slightly more frequent in women who have borne children. It usually occurs about the time of the change of life. Any unusual discharge or bleeding should immediately be regarded as a warning signal. This kodachrome (kodachrome projected) shows a cancer growing in the uterus. It early fills and expands the cavity and invades the wall. One can easily understand why such a growth bleeds, and see how it is possible for a surgeon to get a small piece for microscopic examination. Here is the appearance of such a piece of tissue when placed under the microscope. Note the resemblance to the cancer in the stomach. Here is another kodachrome of a cancer diagnosed from scrapings from a uterus.

Cancer of the breast, although very common in women, can also occur in men. It occurs usually after the age of forty. Only 10 per cent of lumps appearing in the breast are cancer. Occasionally a tumor which is innocent may later become cancerous. Many such lumps remain, or may even disappear, and are not cancerous. But some are, and all suspicious lesions should be examined. As an example of such growths here is a kodachrome of a man who was unfortunate enough to develop cancer in both breasts. These are relatively early growths. A close-up shows one to resemble a small, bluish cyst. Usually by the time the patient is induced to consult a doctor the mass is much more evident. Another common variety shows no ulceration, but instead shows a hard, nodular mass beneath the skin. By the time such patients present themselves the mass is of good size and the opportunity for effective treatment is lost. This growth (kodachrome) is so extensive that adequate removal causes mutilation. The tumor extends clear into the axilla and the surgeon has to remove small

* Presented before the Institute on Geriatrics, sponsored by the Indiana University School of Medicine and the Indiana State Board of Health, at Indianapolis, Indiana, on May 22, 1946.

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extensions such as these. As a consequence the patient has disabling residual scars.

The function of the pathologist in cancer study is to distinguish between innocent and cancerous growths. Mutilation may often be avoided. Innocent or benign tumors grow without spreading, usually are well-contained, and can be completely removed by the surgeon. Cancerous growth tends to insinuate among normal cells and finally is carried through lymph vessels and sets up scattered growths in various organs. This is the danger in cancer. We have only three methods of treating cancer presently approved by medical science. They are surgery, x-ray, and radium. Not a single method is effective against cancer cells once they are scattered throughout the body. The cause of cancer is unknown. Our only protection is to be constantly alert and through periodic examination catch such growths in the early stages. This will prevent the scattering which renders us helpless.

Let us consider only one other cancer—cancer of the lung. Cancer of the lung seems to be increasing, and it is one of the most difficult problems in medicine. A patient has difficulty in doing without one lung. Should cancer be scattered throughout both lungs, the condition is hopeless.

Finally, a few words about the American Cancer Society. Its table of cancer danger signals is excellent:

Any sore that does not heal.
A painless lump.
Irregular bleeding or discharge from a natural body opening.
Change in wart, mole, or birthmark.
Persistent indigestion.
Persistent hoarseness or cough.
Change in bowel habit.

Most of you have contributed to the current campaign to cancer control. You will be interested in knowing how your money is spent. Forty per cent was allocated to an organized, systematic investigation of phases on which we are now ignorant, to be directed by a national group. Sixty per cent is retained within our state. It is used for general education, for the establishment of examination centers, and, particularly, to buy the expensive x-ray machines and radium which are so necessary in its treatment. A considerable amount is set aside for the hospital care of cancer patients and for the services of visiting nurses for those cases who are able to remain at home.

CARDIOVASCULAR-RENAL DISEASES*

R. A. SOLOMON, M.D.

INDIANAPOLIS

Longevity is a vascular question expressed in the axiom that "a man is as old as his arteries." The cardiovascular-renal diseases are the most frequent of all the chronic diseases. In the decade of fifty to fifty-nine this group causes 40 per cent of all deaths, and their frequency increases with each succeeding year of life. Unbiased investigation indicates that their increasing prevalence is due to the fact that we escape the infectious diseases in our younger years and live to succumb at a more advanced age to one of the chronic diseases.

The concept that diseases of the heart and arteries after fifty are the inevitable results of the aging process is erroneous.[1] The normal changes in structure and function of the heart and arteries that appear with age are few and simple, and do not give rise to clinical disease nor do they lead directly to death. It is true, however, that the circulatory system is not as competent in advancing years as it was in youth. This, like the rest of the aging organism, is due to loss of its resiliency and the power of quick adaptation to changing external stimuli.

In this older age group an elevation of systolic pressure is commonly found which is quite distinct from true arterial hypertension. This systolic hypertension with its increased pulse pressure is not caused by a narrowing of the peripheral arterial bed and does not throw an added strain on the heart and arteries. It is the result of changes in the aorta and large arteries, and is a compensatory mechanism. Its effect on the dynamics of the cardiovascular system is a beneficial one, and it does not endanger the health or life of the individual.

A sharp distinction must be made between this normal aging of the cardiovascular system and the group of diseases that manifest themselves with particular frequency in older persons. Only in this way can we hope to discover the causes of the latter and ultimately prevent, or at least retard, their development.

The conditions responsible for cardiovascular-renal diseases in older persons are chiefly arteriosclerosis and arterial hypertension. Of lesser im-

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[1] *Treatment of the Patient Past Fifty*, by Ernst P. Boas, Year Book Publishers, Chicago, 1944.

portance are syphilis, rheumatic valvular disease, and hyperthyroidism.

Arteriosclerosis may involve any of the arteries of the body. It gives rise to clinical symptoms of disease when it seriously impairs the blood supply of certain vital organs, especially the heart, brain, kidneys, or the lower extremities. Its cause still remains unknown. It occurs usually after forty years of age, and is about four times as frequent in men as in women. Hereditary tendencies are commonly seen in its development, and diabetes seems to favor its occurrence.

The clinical manifestations of arteriosclerosis depend upon which of the vital organs is chiefly involved. With increasing changes in the coronary arteries, angina pectoris, coronary insufficiency, and cardiac infarction result. The fact should be emphasized that diagnosis of coronary artery disease is based chiefly upon the history, since there may be no physical or electrocardiographic abnormal findings. In men over forty any pain in the chest, neck, arms, jaws, or epigastrium induced by physical effort should arouse suspicion, and calls for careful examination, including electrocardiography. With proper treatment life may be considerably prolonged. However, tactful handling of these individuals is of utmost importance. Some physicians so frighten the patient that the psychic effects are far worse than the symptoms of the disease. One should be as encouraging as possible, at the same time making the patient realize that his future depends to a large extent upon himself. There is no evidence indicating that in the average case the life of the individual can be prolonged by stopping all activity and making a semi-invalid of himself. It usually leads to psychic and moral changes and unhappiness. When diabetes is present these patients usually do better when their blood sugar is a little higher than normal, and when a little sugar is excreted in the urine from time to time. In spite of all that has been written, cardiac infarction too frequently continues to be mistaken for acute indigestion, gall-bladder disease, and other abdominal disorders.

Arteriosclerosis of the cerebral vessels affects the brain in the same way that coronary sclerosis affects the myocardium. There may be transient local anoxia with loss of function of the affected area, or a prolonged insufficiency of the cerebral circulation may result in death of the affected nerve tissue with a resulting irreversible lesion.

Arteriosclerosis of the vessels of the lower extremities gives rise to intermittent claudication with pain in the calf muscles on walking. Ultimately ulceration or gangrene develops as a result of gradual arterial obliteration or following thrombosis of a diseased artery. Palpation of the pulse in the arteries of the lower extremity and the use of the oscillometer are important aids in diagnosis.

The other important cause of cardiovascular-renal disease in advancing years is essential hypertension, characterized by elevation of both systolic and diastolic blood pressure. Emotional stimuli raise the blood pressure, and the initial reading taken in the physician's office is often inaccurate. The underlying mechanism is a state of peripheral vasoconstriction which retards the flow of blood from arteries to veins and places an increased burden on the heart as well as on the arterial system. The arteries of the heart, brain, and kidneys are chiefly affected, and it is in these organs that the complications occur. The cause of this disease in man has not been established. Hereditary factors play an important role and obesity increases its frequency. It usually occurs after the age of forty-five and is more common in women than in men. The importance of examination of the eyegrounds in this disease should be emphasized. The progressive symptomatology usually follows one of three forms, depending upon where the chief strain falls, namely, the cardiac, cerebral, and renal forms.

In the cardiac form, hypertrophy of the heart or coronary artery disease result, with ultimate congestive or anginal heart failure. In the cerebral form, a vascular accident; and in the renal form, renal insufficiency and failure terminate the picture.

The resistance of the organs of different individuals to the effects of hypertension varies tremendously. The prognosis in younger individuals is much worse, while older patients commonly tolerate persistent hypertension quite well. The height of the diastolic pressure is of more significance than the systolic. The causes of death in the order of their frequency are cardiac failure, cerebral vascular insults, coronary artery disease, and uremia.

The spontaneous marked variations in blood pressure have led to many false therapeutic claims. The hypertensive patient who has no symptoms and whose blood pressure is not excessively high frequently requires no active treatment, and many are made worse by injudicious advice and therapy and radical restrictions of all sorts. The blood pressure should not be taken too frequently, and attention diverted from it. It is usually not advisable to reveal the exact level of the reading. Treatment is directed to the regulation of the patient's life and to reassurance and allaying of his fears. Excesses of all kinds should be avoided and sensible habits of living followed. An occasional vacation with physical and mental relaxation and moderate exercise, especially walking, are helpful. The diet should be a normal, well-balanced one. No particular food restriction will reduce the blood pressure or change the course of the disease. Protein is not harmful in spite of moderate albuminuria, and the restriction of red meats or eggs is without scientific basis. In the absence of edema, salt need be only moderately restricted. Except in persons sensitive to caffeine, coffee and tea may be allowed in moderation, and mild alcoholic drinks and smoking are often permissible if used with discretion. Re-

duction in weight is advisable in the obese patient.

There are no drugs that will permanently lower the blood pressure. Potassium thiocyanate will give symptomatic relief in selected cases, but must be used only with laboratory control of the blood level of the drug. Of all the drugs, phenobarbital and other sedatives are the most useful in maintaining the blood pressure at a somewhat lower level by controlling the nervous and emotional reactions of the patient. The most effective therapeutic measure we possess is probably that of a week or two of bed rest from time to time.

The handling of elderly patients with cardiovascular-renal disease is well expressed by Longcope: "As I grow older I have less and less sympathy with the conscientious efforts merely to extend life in old age. The curtailment of activities, the tender nursing, the humane and assiduous attention of doctors are likely, too frequently, to carry the aged tottering by the danger point and leave them helpless, doddering wrecks of humanity—it is the duty of the doctor to preserve not only health and life, but joy of living; and if most of us had to make our choice we would take the latter. Why ward off death if in the attempt we kill living?"

ABSTRACTS

PROBLEM OF IMPAIRED HEARING RESTS ON TREATMENT AND CURE

Emphasis in the problem of impaired hearing should be placed on treatment and cure rather than on prevention, according to A. C. Furstenberg, M.D., of Ann Arbor, Michigan.

Writing in the September 21 issue of *The Journal of the American Medical Association*, Dr. Furstenberg states: "I have never been convinced of the truth of the often-published statement that 75 to 80 per cent of all cases of impaired hearing are preventable, and that this large proportion of its victims could have avoided their affliction had it been identified early and had proper methods of prevention been instituted. How can one prevent a degeneration of the auditory nerves which often occurs as the result of severe toxic diseases? How are physicians to keep the eustachian tubes of children in working order and the middle ears free from infection during the course of diseases which infect the upper respiratory tract, particularly measles, scarlet fever, mumps, and whooping cough?"

World War II saw the first practical adoption of a program for the treatment of deafness. "I point with pride and with a deep sense of gratitude," the author writes, "to those far-sighted and efficient representatives of the Army and Navy who created an epochal program of service by the establishment and efficient operation of four centers for the rehabilitation of the hard of hearing in military service. These important units located at strategic points in the United States, Deshon General Hospital at Butler, Pennsylvania, Borden General Hospital at Chickasha, Oklahoma, Hoff General Hospital at Santa Barbara, California, and the U. S. Naval Hospital at Philadelphia, have done a colossal job and have achieved memorable progress in the care of the hard of hearing that will not fail to attain lasting recognition. The pioneers in this field wisely combined all available talents—those of the otologist, psychiatrist, psychologist, physicist, electrical and acoustic engineers, and speech experts to function in an integrated and cooperative program that has rendered service of inestimable value to the unfortunate persons whose hearing was impaired in the line of duty. It remains now for civilian physicians and for public health and welfare agencies interested in this field to become familiar with the yeoman service of these great centers and to establish several more along similar lines geographically located to render the greatest possible service to the people of this county. Unfortunately, progress in civic agencies is frequently slow, but the impetus given this magnificent program of service to the hard of hearing by military personnel is destined to inspire, if not demand, a similar plan of action in civilian life."

DOCTORS REPORT TWO CASES OF RARE DISEASE CARRIED BY RATS

A new complication of a heretofore rare rat-borne disease, the first of its kind to be recognized in the United States, is reported in the August 17 issue of *The Journal of the American Medical Association*, by three Rochester, New York, physicians.

They state that they treated two patients suffering from a kidney infection caused by leptospiral organisms, which are carried by rats. This infection usually affects the liver.

The authors, W. W. Stiles, M.D.; J. D. Goldstein, M.D.; and W. S. McCann, M.D., of the Departments of Bacteriology and Medicine of the University of Rochester School of Medicine and Dentistry, state that "instances of this 'pure' renal form of leptospirosis are fairly common abroad, but prior to this report no cases have been recognized in the United States. The two patients observed in Rochester are the first confirmed instances of anicteric leptospiral nephritis to be reported in this country."

The first patient was a schoolboy, aged seventeen, who had symptoms of vomiting, diarrhea, headache, severe backache, and a temperature of 103 F. He had been swimming almost daily in the Erie Barge Canal near Pittsford, New York, and although the canal was known to be infested with rats he was not aware of any direct contact with the rodents. He was aware that water had entered the upper respiratory passages on several occasions. He was discharged from the hospital on the nineteenth day after the onset of his illness, and remained in bed at home for an additional five weeks. The patient was treated with a high protein, salt-free diet, and given a large amount of fluids.

The second patient was a dairy worker with the same general symptoms. The article points out that "for the past several years the patient had worked in a milk pasteurizing plant in Pittsford, New York. He said that rats were frequently seen about the plant and that approximately three weeks before this illness one of them had become caught in the mechanism of a bottle washer, and its macerated tissues had been thrown about and over him." Fever persisted until the sixteenth day of illness in this patient. He remained in bed two weeks at home after discharge from the hospital.

The infection was discovered in both instances after a total of sixty guinea pigs were used in testing the bloods of the patients. The guinea pigs are very susceptible to leptospira.

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Editorials

THE JOURNAL'S PLATFORM

1. **Preservation of American Medicine through voluntary service to the sick.**
2. **Advocating full-time county health officers, locally appointed.**
3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

THE JOURNAL PLATFORM

Some time ago we suggested to the Council that THE JOURNAL establish a platform, setting up a definite plan for the Association for the near future. The Council was unanimous in adopting the suggestion and endorsed the various "planks" as set forth. Later, at a meeting of the Editorial Board, the matter was fully discussed, resulting in the platform which now appears at the masthead of the editorial pages.

We long had felt that it would be well to have some definite objectives, something to look forward to, something which might serve as a future goal. We believe that the platform as now outlined covers the most important phases of Hoosier Medicine, and we further are convinced that it is entirely possible to bring each point to fruition. It simply means that we all must do our stint in making these things possible.

At the Editorial Board meeting it was suggested that from time to time members of the board write an editorial based on some one part of our program, this to be an informative portrayel of just what it is all about. Other association members will be asked to discuss certain phases of the program, and with all this help we hope to have the whole program fully understood by everyone of our members.

We have heard the criticism, which we believe is just, that one of the glaring faults of medicine is that it has had no definite, concrete program; that there has been no concerted effort to bring about this or that change; no united effort to accomplish a stated purpose. We all are more or less agreed that certain things are needed, things that should be done, things in which we might all participate, but, as we have said, this has in no sense been concerted. Hence, we believe that, at least for Hoosier Medicine, with a platform before us each month we may be able to accomplish more.

There is not a single item in this list that is not of greatest importance to us all; it would be a task to point out any single suggestion as being more important, although the first one, relative to the preservation of American Medicine, at the same time assuring full medical care for every citizen of the nation, is probably most outstanding.

But there are other important things; the maintenance of the present high standards of our University Medical School, and seeing to it that it keeps abreast of medical progress. This, of course, means that we still believe that the full four-year course should be given at Indianapolis.

Disease prevention, state-wide, is another important factor. In the matter of diphtheria, as we all well know, it is now a preventable disease, one that can be completely wiped out if we but make a concerted effort to do so. Undulant fever, now come to be a most important consideration in medical matters, can be eradicated if we coordinate the efforts of all concerned in such a program.

As we have remarked, you are going to hear more and more about the program, not only from the editorial staff but from members from over the state, all of whom are conversant with these subjects. In fact, individual members, without solicitation, are hereby invited to join in the chorus, or perhaps give a solo, expressing their opinions on any of the subjects concerned. One of these days we are going to celebrate our 100th anniversary, and we hope that when that day arrives we shall have accomplished many of the things we have set out to do.

We shall be glad to have your reactions to the platform, as published.

THE BRUCELLOSIS PROBLEM

And it is just that—a problem. For some reason the medical profession has been slow to recognize the seriousness of this disease; for a long time too many refused to believe that there was a chronic type, but as of today the profession, generally, has awakened to the importance of an understanding of brucellosis and are alert to its dangers.

In the October number of THE JOURNAL we published three articles on this subject, all by men who know full well what they are writing about, and we trust that every one of our members has read and fully digested what has been said in this issue.

Dr. Thurman B. Rice, of the Indiana State Board of Health and long a student of this disease, mentioned that back in 1928 a guest speaker at one of our state meetings told us that undulant fever was more important to the people of Indiana than typhoid fever. We recall that there were many doubting Thomases in the group who heard that address, and remember several physicians openly stating that they did not believe such "truck."

But some of our younger men became interested in undulant fever; they studied it; they made laboratory checks, and then they began to talk and write about it. One source of personal satisfaction is the fact that Indiana has pioneered in this work; our magazine for several years past has published many articles and bits of comment thereon, all the while urging our readers to more thoroughly familiarize themselves with this important subject. And now we present three exceptionally well-written articles, each authored by men who know their subject, giving a complete clinical picture of both the acute and chronic types.

Dr. Neal Davis has written many articles on this subject, having interested himself in the matter several years ago. We present a new writer on the subject, Dr. M. J. Moss, of Yorktown, who covers the subject of chronic brucellosis very well. He goes into detail in the matter of diagnostic procedure, presenting a table of the predominant symptoms in seventy-four of his patients. He devotes considerable space to therapy, detailing his experiences, and recommending various treatments.

He also presents a very clear clinical picture of three of his cases, which are very informative. His summary is exceptionally well done and gives a comprehensive picture of the disease, diagnosis, and treatment.

We still are greatly interested in the study of brucellosis, and are presenting material concerning it from time to time, even at the risk of being accused of harping on one subject too long. Brucellosis is not a *rare* disease in our state, but too often it is not recognized until it has become chronic, when the management problems are materially increased. We are more than pleased that this subject is on the active agenda of the Indiana State Board of Health, and that the board has organized a special group for the study of brucellosis.

It will require months, perhaps years, of patient, well-organized propaganda to put this subject before the public and arouse them to action. Indiana Medicine has played an important role in the study of this disease, and we trust that as time goes on more and more of our members will have enlisted in the campaign.

CASE RECORDS

One of the most valuable assets a doctor may possess is intimate case records, records of his daily work. These need not be elaborate, going into full detail in every case, but should show the diagnosis, the treatment, and the progress of the case. However important case records may be, it is unfortunately true that many physicians have few case records of much import, and we have known men engaged in medical practice over a long period of years who kept no records.

The modern hospitals, particularly the "approved" hospitals, have learned the importance of case records. In fact, unless case records are properly kept the hospital finds itself on the non-approved list, the "list" being maintained by both the American Medical Association and the American College of Surgeons.

It might generally be presumed that the average country practitioner does not pay much attention to case records; hence, it is refreshing to read a news story of a southern Indiana physician, in practice almost fifty years, who had found time

to take care of this important phase of his practice.

Dr. H. S. Dome, of Tell City, has very complete records of every case he has treated since 1901; he keeps these records in a small book, filing them away very carefully after the book is filled. It is said that he has his own system of abbreviation, using many Latin terms, hence, gets a lot of information in a line or two.

Doctor Dome is a graduate of the Kentucky School of Medicine, and located in Spencer County immediately after graduation. Later he took a year's vacation, spending this time in California. Returning, he was located in Evansville for some twenty-four years, going back to Tell City some seven years ago, where he again is in active practice, maintaining his long-established practice of keeping case records.

Occasionally we have asked some physician to prepare a paper on his experiences in certain fields of medicine, and have been advised, "I know this would make interesting reading, but the fact is that I do not have any case records." Much worthwhile information relating to the practice of medicine is lost because of this lack of records. Some physicians will get up in the local county medical society and talk most entertainingly and intelligently upon a given subject, yet, due to the lack of records, would be unable to prepare a paper on the subject.

The average young practitioner does a pretty fair job of record keeping, having had this training in medical school, and in his internship one of his daily jobs was to make entries in the hospital records. At the same time it is not too late for the older practitioner to about-face and begin some sort of record-keeping.

We recently saw a case record prepared by a busy young man in one of the specialties; it was a 5 x 7 card, and the entries written in abbreviations, for the most part. Every time he saw this case the record was placed before him, and he made such new entries as were pertinent. A paper of more than a thousand words could have been written from this one record, and with not too much trouble.

On the other hand, we too commonly have heard a doctor say, "Well, now let's see; just what did I give this man? I saw him a long time ago and have forgotten most of the details of his case."

Again, the physician who goes into a court case with his case record in his hand is extremely well fortified; he can answer questions promptly and intelligently, and perhaps save himself some embarassment when the questions come flying at him.

Keep up your records; they are the most valuable asset you have.

This issue is devoted to Geriatrics, Indiana having been one of the first states to sponsor an Institute on Geriatrics.

OUR FOOD SUPPLY

The disturbing information has reached us from official Washington that our food supply in 1947 will not show much improvement over the present year; that meat in particular will continue to be one of the "wanted but not found" items—all this in the richest nation in the world, long known as the "land of plenty!"

Many are the economic causes that have brought this about, some of them beyond the understanding of the average American citizen. Not too long ago we had a "kill the piggies and plow under" program that astounded most of us. We could not fathom the justification of such a program; most of us still are in the dark about it.

Then came the war; farmers were told to speed up production, plant more acreage, raise and market more live stock; in addition, the farmer's wife, who for years had been the supervisor of the "chicken department" of the farm, raises a few hens for the eggs they produce, plus a few fryers and roasters for the family table, occasionally sending eggs and maybe a chicken or two to the village grocer.

In a matter of a year or two our grain elevators were filled to full capacity, unshucked corn stood in the fields, millions of cattle, hogs, and sheep were ready for the market, and our vegetable crop had reached fabulous proportions. It appeared that America would do a good job of feeding the world; and we now are doing just that, although some of those nations seem almost insatiable.

Then came the change, the explanation of which seems never to have been satisfactory; at least it never has been generally accepted. Price control, long in effect, seemed to have little to do with the fact that commodities which had been on the market in generous quantities began to disappear, this soon to be followed by varying degrees of "black market."

As of today, even after the greatest grain crop in our history, plus all the other foodstuffs that are grown here, we find shortages that up to this time had been unknown. The administration recently declared that there was no serious shortage of meat and that in a very short time our markets would be filled with the choicest cuts; that other foodstuffs again would be available in large quantities; and that was a week or so ago. Now comes the opinion from Washington that the present shortages will, for the most part, continue throughout 1947. Just whom are we to believe? We know that there is a shortage of many of the things we have come to believe we must have almost daily, and those of us who have taken the family market basket and gone to our regular grocery-market have found the cupboards bare all too often.

There is, to our notion, a serious health menace in some of these shortages; the American people as a rule are not vegetarians; they never have had to

depend on a fish diet, and while eggs are acceptable to most of us on occasion, an egg diet becomes somewhat monotonous, to say the least. We have a large population of working men who *must* have meat. They just cannot get along without at least a generous portion of the daily amount to which they have been accustomed.

One need not make a very extensive canvass in any industrial community to establish these facts. We have talked with dozens of these men, men whose daily stint is in the steel mills, for example, where they work at the rolls where the temperature is extremely high. These men say that a milk and egg diet, plus an occasional sandwich of "lunch meat," simply does not make for efficiency in this work. And this is generally true of all industry; even the man on the automobile assembly line, while perhaps not engaged in a manual labor so strenuous as the man in the steel mill or the man at the oil stills, yet he is expending energy which must be replaced.

We recall that during an earlier meat shortage a considerable group of coal miners issued the ultimatum that unless they got meat they would not enter the pots; somehow or other they got meat.

We do not know the answer, but we believe that someplace in our economy there is something wrong; apparently we do not have the answer to these problems. Our food markets are woefully short of supplies, this not alone at the meat counters. Locally, we have seen lines of hundreds of people, mostly women, standing in front of a market that will not be open for an hour or two, patiently waiting for the doors to open and hoping that they will be able to buy food.

And this line is by no means limited to the home folks. We know of dozens of instances in which people drive in from other communities, even from the far north side of Chicago, because they had heard that some Indiana store or market has meat and other foods. People no longer ask for a porterhouse, a sirloin, a prime rib-roast; they ask, "have you *any* kind of meat?" Housewives have long since learned how to prepare the "cheaper cuts," as they used to be known, and make them palatable. These cuts, by the way, no longer exist; there are no cheap meats of any sort.

The problem is an acute one because of the effect of a non-meat diet on the man who does hard labor; we cannot reconvert our dietary system over night; it takes generations to do that. This is no time to discuss the fact that certain nations thrive on a rice diet; others on a fish diet; still others on a vegetarian diet; those things are all well enough for a people who for hundreds of years have lived on these things, but not for a nation that has had a varied diet ever since it has been in existence. We are hopeful that the acute problem may be solved, and soon.

Editorial Notes

Dr. Thurman B. Rice continues to preach the doctrine that undulant fever is one of our top-flight enemies. In our recent General Practice of Medicine Number appeared several articles on this subject, each of the writers stressing the importance of early recognition of the disease. The medical press all over the country seems to be awakening to the importance of this ailment, and we predict that in the next few years undulant fever will attract the attention of most physicians.

At a recent meeting of the Indiana State Health Advisory Council plans were outlined for several changes in existing laws, all looking toward a more successful fight against the many diseases that are at least controllable. Chief among the matters discussed was the subject of full-time county health officers, a program that is endorsed by our association. Other matters discussed were the undulant fever problem, an extension of the x-ray screening tests throughout the state, and the dental care program now in operation.

Senator Taft, of Ohio, recently declared that he was not at all in accord with the fantastic proposed legislation of Wagner, Murray, and Dingell, yet he stressed the fact that the health of our people must be safeguarded. He declared that the health of the nation must be placed squarely on the shoulders of the medical profession. He stated, "It is up to the doctors to recognize existence of the problem and to take an active part in its solution." That is just what the medical profession has been doing for a long time, and proposes to continue doing, but with this difference that organized plans are being put into effect whereby the entire profession cooperates to the fullest extent.

Speaking of "health columns" in the lay press, the *Marion Leader-Tribune* observes: "Occasionally an editorial writer will discuss conditions involving public health, locally, if that may be construed as a 'medical discussion,' but rarely do newspaper editors, down to the village weekly, where the editor may also be a linotype operator, pressman, and reporter, discuss medicine from the technical viewpoint. Editors value their necks too well to hazard such a practice." Our observation has been that most newspaper folk are very fair about such matters; those who regularly contribute columns usually are careful to see that the writer is a man of standing and ability, and who can discuss health matters in a manner that will be understood by the average layman. Occasionally one of these writers seems to go completely off the beam, but in the main they are doing good work.

The National Commission on Hospital Care has announced that Indiana needs 4,500 more hospital beds to assure adequate hospital care for her citizens. A nation-wide need for 195,000 additional beds is also announced.

A down-state physician is reported to have written a book. Chances are this will be another "seller," according to a story in a recent number of the *Saturday Evening Post*. In an article concerning the Book of the Month Club, the writer reports that books written by physicians always are big hits. He further quotes an official of the Club to the effect that when they buy "mailing lists" they pay higher prices for a list of medic's books than for that of any other profession. "Doctors are great readers," so the report goes. On the other hand, the same authority states that lists of dentist's books are of little value, since "dentists are not great readers." (Remember, these are but quotations; the editor expresses no opinion thereon!)

United States Army Engineers, making a preliminary survey of the site for the new Veterans' Hospital, on the campus of the Indiana University Medical Center, have found that much of the property is located in an old swamp, which means added cost in preparing the foundation. This tract, donated by the City of Indianapolis, consists of twenty acres and is ideally located in that it would be convenient to the medical school, thus making it easily accessible to those who serve as teachers in the school as well as members who would serve on the staff of the new hospital.

The project has the full backing of the Washington authorities; plans are in the making; and it is assured that the buildings will be constructed as speedily as possible.

A United Press dispatch, under a recent New York dateline, remarks: "If an enemy began spraying rockets with atomic warheads over the United States today, Indiana might be a pretty safe place to be in." It goes on to mention the numerous caves we have, down in southern Indiana, especially mentioning the Wyandotte Cave, in Crawford County, which could hold the entire population of Indianapolis.

There are some one thousand caves in America, all of which are now declared to be under study by a joint Army-Navy munitions board, which opines that these caves might be pretty handy in case of an attack from the air by an enemy. Since the temperature in these caves is rather uniform, ranging from 52 to 55 degrees, a residence therein for a time might not be too unpleasant.

Our personal experience, limited to Wyandotte Cave, leads us to believe that a stay in such a spot, under wartime conditions, would be no particular hardship provided the bats could be persuaded to stay out of our hair.

A national child health survey is under way, financed by the Federal Government. Some eight thousand dollars will be expended in Indiana in this study, which will be carried out under the direction of the Indiana State Board of Health and the American Academy of Pediatrics. Dr. E. R. Carlo, of Fort Wayne, head of the Indiana pediatricians' group, and Dr. Walter Stoeffler, pediatric consultant of the Indiana State Board of Health, are in charge of the survey.

The American Hospital Association announces that plans are being made to provide a retirement program for employees of private hospitals. As matters now stand these employees are not covered by Social Security, this fact being responsible in many cases for the inability of hospitals to secure the services of the higher class of such employees. The plan contemplates the raising of funds by joint contributions of the institution and the employees.

The Randolph County Hospital, which closed for a two weeks' "vacation" this last summer, is being completely reorganized, according to press reports. The closing of the hospital brought about much discussion on the part of the physicians and local residents, two of the county newspapers making quite an issue of it. It was discovered that the hospital was under the jurisdiction of the local Board of Trustees, and that the county commissioners had no control over it. Now the plan is to have the commissioners in full charge, and they will appoint the board, look after the financial affairs of the hospital, et cetera.

The program of the Veterans Administration relating to "home town" care of veterans seems to be progressing, according to a recent announcement. This care may now be had in twenty states, with several others planning to sign up soon. The program is in full operation in thirteen of these states at the present time. This "home town" care is available to those who cannot conveniently travel to Veterans Administration hospitals, many of which already are crowded. It is stated that as of August twenty-ninth there were 80,133 such patients in these institutions. Almost two-thirds of this group, however, were being treated for non-service-connected disabilities. In the same bulletin from the Bureau it is stated that nine out of ten veterans making applications for GI loans want this money for the purchase of a home. More than six hundred million dollars have been loaned by the Bureau, several of these loans already having been repaid. Another interesting part of the story is the fact that all veterans admitted to these hospitals undergo a complete chest x-ray examination, this in order that incipient cases of tuberculosis may be located.

It is announced that plans are being studied for the establishment of a clinic in connection with the Ball Memorial Hospital, at Muncie. The clinic would be a non-profit organization, with a special building to be erected on the hospital site, the expense thereof being met by members of the clinic staff, all of whom are regular members of the hospital staff. The suggestion was initiated by Dr. William C. Moore, a Muncie surgeon.

The United States Food and Drug Administration announces that it finally is doing something about the oyster situation, that is, defining just what "oysters" means. In the oyster trade the terms, "oysters, raw oysters and shucked oysters" are commonly used, terms that mean little to the average consumer. Oysters also will be "sized," that the consumer may get the big fellows or the little ones, as he may choose. Some are so large that they run only twenty to thirty to the gallon; a bit too large, we think, for use on the half shell.

Well, well, the "Old Indiana Doctor" is back in Indiana! He has been absent for some years, probably due to war conditions, but apparently has learned that Hoosier folk again are in the money, and are still gullible. According to a recent press report one of these fakers made an appearance in a country district in northern Indiana, and convinced an old couple that one of them was in an extremely serious condition, and that, fortunately, he possessed the ability to cure her. At first he asked an exorbitant sum for his services—several thousand dollars, in fact, but the couple could raise only a few hundred dollars in cash. This was rolled up in a bandage and bound over the affected area, to remain there until the "doctor" came back some time later. When he failed to appear the couple removed the "dressing," only to find that the money had been extracted therefrom. Sometimes we think that there are a dozen of them born every minute.

Remember the old "feud" with the homeopaths many years ago? We are reminded of this in reading in the September number of *The Journal of the Missouri State Medical Association*, an article, by Dr. R. E. Schlueter, on "The Personality of William Beaumont." He quotes from a letter by Beaumont to a lay friend, who had asked the former to consult with a homeopath in the illness of a daughter: "Yours, Henry, of this morning was received and kindly appreciated. No appreciable offense was felt at the course you had taken for the rescue of your infant. But your reason of sense and propriety will excuse me for declining your request of associating my professional character and reputation with the infinitesimal part of nothing, alias Homeopathy, Quackery, and Humbuggery, et cetera, by discontinuing 'my usual attendance' at present."

Cedar Lake, in southern Lake County, has in recent years experienced quite a building boom, many folk from Lake County and from Illinois communities having established their year-round home there, until now the former resort has a permanent population of over five thousand. They want to make it a modern city; they have recently established a fire department, of the volunteer variety; they have a new theater; they want a modern drug store; and they want a doctor as a permanent resident. The civic association is certain that a medical man will find plenty of work to do there, and have announced that even in the present housing shortage they are holding a house until January first, in the hope that some physician may be persuaded to locate there. Some physician who prefers not to have too much work, who likes to cast a bait into a fairly large lake; who likes a small sailboat or outboard craft, and who likes to live in a prosperous farming community, as well as near a lake resort, would do well to get in touch with Cedar Lake folk.



BUY UNITED STATES SAVINGS BONDS!

A nation-wide promotion campaign will be staged from November 11 to December 7, 1946, in which Americans will be urged to buy United States Savings Bonds. The theme is "self-interest"—individual security, community business advancement, and national prosperity.

The Minute Man, symbol of defense, has now placed his plowshare in the foreground to become the new insignia of peacetime security—the trademark of the United States Savings Bond.

President's Page

The overall picture of medical care for all people has assumed enormous proportions. One not familiar with the trend of the times in this direction is due for a rude awakening when given the facts. As we move along in the reconversion period, different organizations have arisen for aid and assistance in the plan for better medical care. The program, covering all the different groups, as it now stands, is very wide and diversified, each group with the good intentions of trying in their particular field to give aid to the sorely distressed. As much as we disapprove of interference in our profession, we are compelled to recognize the fact that the field is too broad for a mere handful of physicians, in comparison with the population of our country. Therefore, I believe that the medical profession should endeavor to co-operate with these groups, assisting them in every way possible to iron out their difficulties, thereby making their individual programs fit into the general plan that must be agreeable to the physicians of America. Any other way, and this is a warning, is doomed to failure; for, after all, who but the men and women who are educated in this particular field can sit in judgment.

I sincerely believe that all the different organizations have as their ultimate goal the betterment of the health of all mankind. We must all work together, co-operate with one another, and co-ordinate our actions.

A few weeks ago, on the invitation of the officers of the Indiana State Medical Association, representatives of the Medical, Dental, and Bar Association met with us in a special meeting for the sole purpose of attempting to understand the problems that confront each organization, in an attempt to co-ordinate the activities of each association for the betterment of the whole, thereby establishing a public relations program which I think should, and will, be a set activity, meeting as many times a year as necessary. As we learn and understand the problems of others, ours do not seem so big.

The Inter-professional group is another very worth-while undertaking, especially from the public relations standpoint. These meetings have been very successful in the past few years of its existence. Great things have their origin in these meetings, and I am sure that greater things will come. Let us all give the activities that promote good will and fellowship our loyal support.

The American Academy of Pediatrics, working through the Indiana Pediatric Society and the Indiana State Board of Health is attempting to promote and form some plan for a survey of all preschool and school-age children, with the ultimate purpose in view for the prevention and eradication of diseases peculiar to childhood. This, in my opinion, will be a step forward, providing that there is nothing undercover and that this action can be freed from any suspicion that some one or some group might make an attempt to use this activity as an excuse for socialization of medicine; otherwise, it will supply the profession with a much needed program that has been neglected, for I believe that a healthy child is the basis for a strong healthy man or woman, and many of the diseases that occur in middle life and old age are attributable to diseases of childhood. On this broad provision, as we see these patients we wish and almost demand that something be done for the correction of these problems in early life.

This, of course, is a very live and important subject. Space will not permit a comprehensive discussion thereof, but let me leave this thought with you: we can easily couple improper care in the child's early life with later developments, for with a diseased body it is hard to find a well-balanced mentality, and this could be and very likely is a strong element in the production of juvenile delinquency, which at the present time is causing great worry to our nation.

J. E. Farrell

MEDICAL RESPONSIBILITY IN INDUSTRIAL HEALTH*

FRED B. WISHARD, M.D.†
ANDERSON

We have recently had an opportunity to go over some medical records which had accumulated during the war years with reference to the employment in our plant of elderly individuals. We were interested in correlating certain basic facts relative to their employability and usefulness, and it is these findings which I would like to bring to your attention.

The employment of large numbers of older men —and I speak only of older men; we employ very few older women—has demonstrated that the medical responsibility in industry increases in direct proportion to the age of the employee, for the reason that the infirmities of age reflect upon one's efficiency and usefulness. In one manufacturing concern an extensive survey was made of some eight thousand men of draft age, employed during the years 1942, 1943, and 1944. These men were all forty-five years or older, and about 40 per cent, or three thousand, were in the sixty to eighty-five-year age group. While many had had former industrial experience—former employees anxious to do their bit in the war effort, retired pensioners, pensioners from other industries, et cetera, a large percentage had never worked on a production line prior to their war employment, coming directly from farms, small shops and businesses, or as casual laborers.

You may recall that there was a story current that *rigor mortis* was the only criterion for rejecting any applicant during the war, and in our case that was about it, for in our particular instance we had over three thousand men from sixty to eighty-five years of age, with all sorts of physical impairments, working in a manufacturing concern on war production. Each applicant was subjected to a complete pre-employment physical examintion for the purpose of evaluating his ability to work in view of his physical limitations, and we found certain somewhat interesting facts in our survey. Routine blood pressure readings which were a requisite part of the examination showed that 28 per cent of these eighty thousand men had a systolic pressure of 175 mm. or over. Some of that might have been due to the excitement of being accepted and that sort of thing, but nevertheless the pressures were all taken with standard mercury baumanometers, and we have reason to believe that the findings were accurate. Almost three out of ten had a systolic pressure of 175 mm., and 10 per cent had over 200 mm., with a correspondingly high diastolic, ranging from 100 mm. to 120 mm., or even more. About one-half of all the applicants showed some definite arteriosclerotic change, such as arcus senilis, palpable radial arteries, et cetera. This was not necessarily associated with a corresponding hypertension, for many with marked arteriosclerosis had relatively low systolic pressures. As a matter of curiosity we used to x-ray the wrists and ankles of these men who showed marked arteriosclerotic change, to see how clearly it could be demonstrated radiographically, and we have quite a library of films which were taken for no other reason than to demonstrate the degree to which one can show arteriosclerotic vessels on x-ray film.

Some 15 per cent had marked varicose veins and other definite demonstrable interference with circulation of the lower extremities. About 1 per cent had varicose ulcers; that is, open, running sores, usually on the inner aspect of the ankle, although some were on the outer, and any number had scars from healed ulcers.

While somewhat over 1 per cent of the male population is normally accredited with inguinal hernia, the incidence of hernia in this group of eight thousand men was 6 per cent. That is, one out of every seventeen men had a rupture on one or both sides. Furthermore, many of these were enormous in size and of long duration. Had I not personally seen some of these hernias I would not have believed it humanly possible to have a hernia as large as some were. No particular effort was made to compel these men to use a truss, for the reason that the whole area was usually so relaxed that no truss would be of material benefit, and we had no assurance that the man would continue to wear his truss after it had been purchased as a prerequisite for employment. To digress a moment, our first policy was to have the applicant buy a truss. Many of these hernias were obviously inoperable, and the man would return with some make-shift affair, something which a drug store clerk had attempted to fit on him in the back room, and besides, many did not have the money with which to buy a truss. Others had worn trusses for years and continued to do so, but beyond that we did nothing. Incidentally, many were wearing them with the herniation completely down behind the pad and were apparently suffering no inconvenience at all. We saw any number of cases where men, in anticipation of getting a job, would go to a drug store, buy a cheap truss, put it on with the hernia down behind the pad and insist that they were quite ready to go to work. These fellows were encouraged to throw the truss away or get their money back if they could.

* Presented before the Institute on Geriatrics, sponsored by the Indiana University School of Medicine and the Indiana State Board of Health, at Indianapolis, Indiana, on May 22, 1946.

† Medical Director, Delco-Remy Company, Anderson, Indiana.

ARTHRITIS

We found that about 30 per cent showed some definite arthritic changes, although only 3 per cent had progressed to a point where it was disabling or where it materially limited the usefulness of the individual. These were mostly instances of osteoarthritis of the spine, with marked limitation of motion of the back in which case any lifting would be contraindicated. Many minor arthritic changes were observed, mostly in the fingers, shoulders, knees, and sacroiliac joints. Thus, about three out of ten from forty-five years on showed something which could be definitely and tangibly said to be an arthritic phenomenon in his skeletal system, mostly in the extremities, although the disabling ones were usually in the back. This was brought out by having the men bend over and go through various motions of the back, and where marked changes were observed films were taken of the spine as a matter of record.

TUBERCULOSIS

We made another interesting observation which has no material bearing here, with reference to tuberculosis. Whereas our pre-war incidence of tuberculous chest lesions, based on some forty thousand films, was 1.8 per cent, the group about whom we are talking showed an incidence of 4.2 per cent, although only a small fraction were considered as being active. This figure was reached by using 14 x 17 flat x-ray films, rather than by clinical examination, it having been our practice for some twenty years to take a routine chest film of every applicant for employment. One out of every twenty-five had some lesion in his chest. The increased frequency of chest lesions in this older group was doubtless due to the fact that there was no widespread interest in tuberculosis control fifty years ago, when they were young, and these men had outlived their lesions.

ECZEMA

About 10 per cent had an eczema on their forearms, hands, or lower legs at the time of employment. This was usually the dry type. An alarming number later developed acute sensitivity to minor irritants and practically every sort of solvent or degreasing compound. In fact, it became quite a problem to put them on any wet operations at all. A considerable number developed a general exfoliative type of dermatitis of such severity as to require hospitalization.

ABILITY TO WORK

Hand-motion studies made of our war jobs in a way similar to the motion studies made prior to the war showed the reaction time of these men to be about 20 per cent less on production work than that of younger men.

ABSENTEEISM

We found the older men to be more regular in attendance than younger ones. They seemed to cherish their jobs and liked them, and took pride in the fact that they were still capable of doing a day's work, whereas a younger man would lay off a day or so a week. The older man would work as long as he was physically able to do so, but when he became ill it took much longer for him to recover.

MENTAL ATTITUDE

The majority of older men enjoy working within the limits of their physical capabilities and approach a job with a better mental attitude than younger men. A younger man looks on a job as a stop-gap, a sort of "Where do we go from here?" philosophy, whereas the older man seems to be pleased with the thought that he is still useful, and with that in mind he takes a greater interest in what he is doing, and when he lays off he is usually sick.

SUMMARY

It was our experience that an older man, in general, is capable of doing about 75 per cent the amount of work on a production line which a younger man would be able to do under like circumstances. The capacity to work is definitely limited in the majority of men in the older age groups, their physiological reserve being comparatively small, and if these facts are borne in mind in assigning them to jobs, and too much is not expected of them, many can fit into the industrial picture, especially in the skilled trades.

It is our opinion, from a medical standpoint, that there are six factors which should be considered in the assignment of older men to jobs:

1. *Cardiovascular Disease*—I mentioned hypertensive conditions and acute heart failure, et cetera, above.

2. *Arthritis*—particularly where the job might tend to accentuate the quiescent condition of the patient.

3. *Skin*—the skin undergoes senile changes which result in an increased susceptibility to industrial irritants, and these old gentlemen should be kept away from solvents, cutting compounds, and things of that sort.

4. *Hernia*—if present, there may be a tendency to strangulation.

5. *Alertness*—the reaction time is lessened, and these men should not be expected to be able to operate fast-moving machinery, because it is frequently faster than their mental processes.

6. *Efficiency*—in general, an older man will put out less quantity of work, but it will be of a better quality.

I have touched upon some observations which we made during the course of the war. I hope that they will be of some interest to you, and I might say in closing that I am getting along myself, and am reconciled to gracefully becoming old, merely for the privilege of once having been young.

MANAGEMENT'S RESPONSIBILITY IN INDUSTRIAL HEALTH*

C. N. SMITH†
INDIANAPOLIS

New vistas of health and happiness have been temptingly exposed by the discussions during the institute today. Thinking of these activities in relation to Industrial Health, management can sense a challenge to accept a share in guiding workers in industry so that all of us may enjoy fully the dividends of science. Yet management must let the dreams of the future act as pathfinders for its responsibility today.

Broadly speaking, management in industry is responsible for maintaining a solvent business. Upon this wide foundation, management builds its function with three strong pillars: the production of a product of most value to the customer; the maintenance of a group of employees, well paid and well cared for; and the payment of a profit to the stockholders who own the business.

Resting on the top of these three pillars, let us place the individual worker. The solvency of the business, the quality of its product and the dividends it pays must all be contingent upon a group of successful individual workers. The sentiments, the emotions, the skill, the loyalty, the families, the fortunes—and the health of each of these individuals, each and all of these factors has a bearing upon the success of the industry. Since the management function is to plan, coordinate, and administer, certainly then, health in industry is well up on the list of its interests. I would agree with Charles Kern that management must work with labor to pierce the pale of indifference of individuals to the problems of aging in industry. And I believe that from Fred Wishard we shall learn more specifically some practical methods that our medical departments would institute.

Frankly, geriatrics is a new topic for management to consider. We have always been apprehensive of the problems and ailments presented in industry by aging employees. Much has been done by many of the nation's larger industries to adjust the jobs to the workers and the workers into the pattern of organizations. To approach aging as an industrial health problem in the enlightenment of today's discussions opens a much broader field of activity than many industries have contemplated with their safety programs. Prophylactic treatment by education and research will be welcomed by both management and labor. Aging is a part of living. We must constantly remember that aged and aging are not to be confused. The aged are people, but aging is a process.

With longevity an established fact, this aging process covers a much longer period of time—time in which management can function to add life to the aging. Industrial health means far more than the absence of disease. Health involves those quantitative attributes of reserve capacities that have been mentioned this afternoon.

Let us look, then, to the specific responsibilities management must assume in the promotion of industrial health.

(1) As management's contribution to the more accurate appraisal of the individual's structure and functional capacities, periodic physical examinations might well be established after the age of forty is reached. The accumulation of personal history as reflected in these studies might go a long way toward the goal of geriatrics.

(2) With respect to job assignments and placement, much more can be added to that already a matter of record. Profiting from the physical appraisal, assignments that constantly challenge the individual may be arranged so that they will concur with his own physical competency. Mutual profit will result—greater interest displayed by the individual—greater effectiveness for the industry.

(3) In cooperation with the State Board of Health, management can function to keep employees informed in all helpful knowledge concerning diseases and disabilities of advancing age. Educational material, booklets, pictures, slide films, out-of-hour courses—all are mediums that are open for development by the departments of education and health. Management can touch only a fraction of the entire group of citizens, but each employee will serve as a tangent from the perimeter of information, touching others continuously.

(4) It is the function of management to provide for continuity of employment pointing towards retirement from industry. Certainly management will recognize and use trained and available employees as long as it is mutually beneficial. No one claims to know when the biologic age of retirement is reached. Since it does not agree with chronologic age, the solution to this problem will go far in making individual retirements from industry distinct and apart from dates now established. If in 1900 life expectancy was forty-seven years and it now exceeds sixty-three years, then management also is keenly aware of the significance of this change. Research and constant study of experiences must be of prime importance in answering the problem of using the maximum service without treading in the threshhold of abuse.

(5) To be able to participate in the benefits of geriatrics, as aging healthfully becomes an established fact, employees must have active intellectual

* Presented before the Institute on Geriatrics, sponsored by the Indiana University School of Medicine and the Indiana State Board of Health, at Indianapolis, Indiana, on May 22, 1946.

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interest as a complement to decreasing physical interests. Broad, active intellectual interests are not obtained by commencement at a deferred age in life. Individuals must form the habit of active interests in learning. These habits are well grounded in the formal education required by the state laws today. If, then, adult education and geriatrics are to be achieved at the end of formal education, we must commence the practice of constantly seeking knowledge. As ten, twenty, thirty, forty and more years in industry have passed, employees will have obtained a broadened interest, voluntarily chosen, which will add life to age. Industry may well consider all means necessary to encourage employees to initiate for themselves intellectual growth. Management must consider subsidizing any desires of individual employees towards these goals.

(6) Lastly, management recognizes that all privileges involve obligations. The right to manage must mean that the objectives outlined at the beginning are fulfilled. The right to work means assumption of the full sense of individual responsibility. Thus, jointly, management can help foster education in adult hygiene so that individuals may assume the obligation of personal effort towards health maintenance. Management knows that the individual urge and will to do is far more effective. Management also recognizes that its responsibility is secondary to the joint responsibility that exists between the doctor and the pastor in effecting the care and well-being of those in advancing years. The spiritual aspect can never be ignored. Growing old gracefully is more than a mere phrase. It is for science to add years to life, but the spirit can add life to the years.

ABSTRACTS

DOCTOR URGES HEART PATIENTS TO LIVE NORMAL, USEFUL LIVES

A Philadelphia physician states that many patients who have serious complications of the heart can be reassured and allowed to live normal lives, according to the October 19 issue of *The Journal of the American Medical Association.*

William D. Stroud, M.D., who is on the Board of Directors of the American Heart Association, points out that there are "many murmurs, especially in the pulmonic area, which are absolutely of no importance from the standpoint of circulatory efficiency or length of life. In fact, many children with definite valvular damage live the full span of life, and others do not develop circulatory insufficiency until the third, fourth, or fifth decade. Certainly their lives can be much happier if their physical activities are unrestricted, and I doubt whether the normal physical activity of childhood plays any part in the progress of the pathologic lesion."

Medicine can aid patients with heart trouble to lead practically normal lives, according to Dr. Stroud. "Most people with coronary insufficiency know the things that bring on pain, such as walking after meals or in cold weather against the wind," he states. "If it is necessary for these persons to make such effort, it is perfectly possible for them to ward off an attack by dilating the coronary vessels with a tablet of glyceryl trinitrate before making such an effort."

The author holds out further hope for the heart disease patient by concluding in this optimistic tone: "I feel that the average patient with a healed coronary occlusion can return to a sedentary occupation part time in about three months. Although it is debatable, because of the possibility of further occlusions, I believe it is safe to allow such patients to drive a car three months or so after their acute episode. Also if they do not have angina of effort three or four months after their original attack any mild form of exercise, such as golf or swimming in warm water, seems indicated, if desired. It is my feeling that too many such patients are made total invalids unnecessarily. In fact, it is my experience that after adequate collateral circulation has developed it really doesn't seem to matter what activities these persons carry on within reason from the standpoint of developing further coronary occlusions. Certainly a patient is a happier and more useful member of his community if he can lead an approximately normal life."

PENICILLIN-MALARIA TREATMENT EFFECTIVE FOR LATE SYPHILIS

Concurrent administration of penicillin and inoculation malaria is the most effective treatment for patients with dementia paralytica, late syphilis of the central nervous system which leads to insanity and paralysis, according to three Baltimore doctors writing in the August 17 issue of *The Journal of the American Medical Association.*

Drs. Frank W. Reynolds, Charles F. Mohr, and Joseph Earle Moore began studying the effects of penicillin in various forms of neurosyphilis at the Johns Hopkins Hospital in October, 1943, with the cooperation of the United States Public Health Service Venereal Disease Research and Post-Graduate Training Center.

The physicians state that "as of December, 1945, forty-one patients with dementia paralytica have been treated with penicillin. Twenty-four of these patients (group A) received penicillin alone in amounts ranging from 2,000,000 to 10,000,000 units in divided doses; the remaining seventeen patients (group B) received from 2,000,000 to 4,280,000 units of penicillin in divided doses concurrently with induced tertian malaria."

Treatment consisted of day and night injections of commercial penicillin into the muscles of the patients. Fifty per cent of those in group A (twenty-four patients) showed improvement in body weight, speech, tremor and handwriting after penicillin treatment. Eleven of this group (46 per cent) also showed improvement in their mental status. On the other hand, 75 per cent in group B, treated with penicillin and malaria, showed these general signs of improvement; while at least ten of the seventeen patients (53 per cent) were improved in their mental status.

"Our results with concurrently administered penicillin-malaria treatment are, we believe, so superior to those with penicillin alone in the treatment of dementia paralytica that it is our present conviction that the former is the treatment of choice," the authors say. "Treatment with commercial penicillin alone may be valuable for patients whose age and general physical condition preclude the use of malarial therapy."

REPORT OF INDUSTRIAL HEALTH CONGRESS

Nearly seven hundred specialists in industrial health from every state in the union attended the seventh annual Congress on Industrial Health, held in Boston, September 30 to October 2. The three-day meeting featured new procedures, technics, and policies developed in the field of Industrial Medicine during the war years.

The congress was sponsored by the Massachusetts Medical Society, the Council of the New England State Medical Societies, and the Council on Industrial Health of the American Medical Association. The program itself was arranged by Drs. Carl M. Peterson, and Harold R. Hennessy, of the Council on Industrial Health of the American Medical Association, Chicago.

Dr. Peterson, who is executive secretary of the Council, said that "these meetings provide an opportunity for the American Medical Association, labor, and management to discuss the medical and health problems facing the industrial workers of America."

Following are some of the highlights of more than a score of papers read at the meeting:

DISPEL "LEAD POISONING" MYTH

Felix E. Wormser, secretary of the Lead Industries Association, New York, assailed the popular belief that eating paint from cribs and toys is a source of lead poisoning among children. "Our investigations cast grave doubts on nearly all of these cases," he said. "This might be expected because crib and toy manufacturers do not use lead paint on their products. Other paint pigments are cheaper and make a harder enamel than is obtainable with lead. Lead paint, because of its extraordinary durability, finds its chief application on exteriors, not on furniture. Hence, the risk to children from chewing painted surfaces on cribs and toys is nil so far as lead poisoning is concerned."

KEY MEN NEED LONGER VACATIONS

Earl F. Lutz, M.D., associate medical consultant of the General Motors Corporation in Detroit, proposed that employees in the management group of industry should take at least a month's vacation in order to maintain their health. This proposal was stimulated by the experience of General Motor's medical department which found that 189 men in the top brackets had died in a five-year period preceding 1944. A study was undertaken, and it was found that deaths from angina pectoris, coronary thrombosis or occlusion, cerebral hemorrhage or apoplectic strokes were prevalent among the executive employees who were subjected to extended hours of work, excessive travel, and unusual mental strain due to the increase of responsibilities which the war effort demanded.

GOOD NUTRITION BASIC FOR HEALTH

Ancel Keys, Ph.D., director of the Laboratory of Physiological Hygiene at the University of Minnesota, Minneapolis, told the assembly that "good nutrition must be a basic in improving both the well-being and work productivity of the employee. This country can easily produce and distribute all the food needed. Much more and much better research will be needed to insure its most effective use."

Louis Schwartz, M.D., Medical Director Chief, Office of Dermatology, United States Public Health Service, Bethesda, Maryland, pointed out a way to fight the spread of such fungous infections as "athlete's foot" in industrial plants. He suggested that each worker wear wooden-soled bathing slippers in locker and shower rooms.

CLINICAL RESEARCH IN INDUSTRY

Walton Van Winkle, Jr., M.D., secretary of the Therapeutics Trials Committee of the Council on Pharmacy and Chemistry of the American Medical Association, said that clinical research, which has led to many great discoveries in the field of medicine, has a place in industry, but that it "is not something to be done in a spare moment. If a health problem requires study or a clinical trial, a competent and responsible investigator should devote his full time to it. If this cannot be done, it is better to abandon the project than to do a poor investigation which, when finished, does not provide a satisfactory answer."

AMERICANS—WORLD'S HEALTHIEST PEOPLE

Morris Fishbein, M.D., editor of *The Journal of the American Medical Association*, pointed out that "the available facts and figures show that the American people are today the healthiest people in the world. Our sickness and death rates are among the very lowest of all the great nations. Nevertheless, there are still evidences of physical deficiencies in some of our population which are capable of prevention and in some instances of correction. The men who were rejected by Selective Service because they could not meet the highest physical or mental standards established for military service by any army could in a good many instances have been made physically fit had the abilities that medicine has to offer been made available to them from the time of their conception until they came before the Selective Service Board. Many registrants were pampered and soft, and were in need of physical conditioning. It is folly for a nation as wealthy and efficient as ours to fail in its utilization of what medical science has to offer for developing a nation that is physically fit," he said, adding: "Not every person who is mentally or physically unfit can be benefited. There are defects that are not preventable. Perhaps 1,500,000 of the 4,000,000 who were rejected could not have been freed of their disabilities nor been greatly benefited by the application of medical facilities. Nevertheless, 2,500,000 could have been made more effective in the occupations which a good many of them filled satisfactorily in civilian life."

Medical Panorama by the Associate Editor

DALLAS ACADEMY OF MEDICINE has organized a Dallas Health Museum for the purpose of dramatizing to the public the factors which contribute to good health. Patterned along the lines of the Cleveland Health Museum, elaborate plans are being made to make it a live, permanent institution of health education.

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METROPOLITAN LIFE INSURANCE Company is conducting a special campaign on heart disease during this fall and winter. In co-operation with the American Heart Association, they will endeavor to reach millions of people through pamphlet distribution, educational films, scientific exhibits, and lay and professional meetings.

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SHORTAGE OF NURSES continues to be prevalent throughout the nation. Annual enrollment during the past ten years has been forty thousand for the entire country. Reports indicate about one-half that number for fall classes. Reasons: Many nurses remaining in service. Only a small percentage going into institutional service. Many continuing education and post-graduate work. Industry taking many. Public health offering appealing field. Long hours, holiday work, and, principally, low pay are the main reasons. In New York City two thousand beds have been closed in municipal and private hospitals because of the nurse shortage, and in other cities sections of hospitals have been forced to close.

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MEDICAL VOLUNTARY PREPAYMENT health insurance plans, in operation, now number eighty-four, with nearly four million subscribers. An increase of 114 per cent for 1945, and 40 per cent for the first six months of 1946. Plans are spread over thirty-three states, and thirteen states have plans under development. Only three states are without a plan or a program. Come spring, forty states should have prepayment plans in operation. Of eighty-four plans, twenty-five offer straight cash indemnity, twenty offer a combination cash indemnity-service contract, thirty-two offer a service contract, and six are classed as miscellaneous. Thirty-nine are co-ordinated with Blue Cross plans. Premium income paid out averages from 63 to 69 per cent. Administrative expenses average about 18 per cent.

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READ: "COMPULSION THE KEY TO COLLECTIVISM."

MICHIGAN DOCTORS have spent $60,000 of their own money in a radio program of public health education. They established nine Rheumatic Fever Diagnostic Centers, twelve Cancer Treatment and six Cancer Detection Clinics. A state-wide study of Child Health Care was made at their own expense. They contributed $112,000 to the Michigan Foundation for Medical and Health Education. They provide free care to veterans with service-connected disabilities by a doctor of the veteran's choice. They established Michigan Medical Service, enrolling one-seventh of the population; and Michigan Hospital Service, supplying hospital care to one-fifth of their population. Some record!

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SOCIAL SECURITY BOARD estimates the cost of "Medical Care Insurance" as follows:

Coverage 100 million persons, $2,600,000,000 to $2,880,000,000.

Coverage 120 million persons, $3,110,000,000 to $3,450,000,000.

Coverage 140 million persons, $3,630,000,000 to $4,030,000,000.

Ten or fifteen years from now:

Coverage 100 million persons $3,520,000,000 to $3,890,000,000.

Coverage 120 million persons $4,220,000,000 to $4,670,000,000.

Coverage 140 million persons $4,930,000,000 to $5,450,000,000.

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CONNECTICUT POSES FOUR pressing medical problems with which every physician should be familiar.

1. John Lewis' new welfare and retirement fund.
2. Organization of the new Public Relations Department of the A.M.A.
3. Developments of hospital and medical care facilities in each state, under the Hill-Burton Bill.
4. Forthcoming study of Blue Cross by the United States Public Health Service.

Of great importance to physicians, and highlighting these problems, are the following meetings set for Chicago:

December 7-8, Secretaries' and Editors' Conference.

December 9-11, Semi-annual meeting of the House of Delegates.

February 7-8, Semi-annual National Conference on Rural Health.

February 9, Annual National Conference on Medical Service.

February 10-11, Congress on Medical Education.

What's Going On In Indiana by the Executive Secretary

Indiana Leadership. "Tell us about it!" That's the request coming to headquarters office about the Indiana Board of General Practice of Medicine. Our neighbor to the east, Ohio, asks about it. From far-away Oregon comes a letter wanting information. This is a tribute to Indiana Medicine—another "first" for our state. The interest shown in the board at the annual meeting indicates that the quota of two hundred founder members will soon be reached. General practitioners wishing to file application for membership may procure blanks at the association office.

——ISMA——

State Meetings Compared. Visits by the executive secretary to the annual state medical meetings in Ohio and Michigan revealed some startling differences in the way these medical organizations conduct their sessions in comparison with ours. For instance, Ohio has two full days of general scientific work, and Michigan has three days of such type program. In both states the House of Delegates elects the councilors. Our method of the counties electing their councilors is much more democratic. Ohio has an annual dinner; Michigan does not, but holds a "grand ball." Our neighbors do not go in for good times at their meetings, neither setting aside time for entertainment like Indiana's Tuesday-night buffet supper and stag party. The meetings in Ohio and Michigan last three and four days, respectively, compared with our two days.

——ISMA——

Talk Mutual Problems. At the invitation of the Indiana State Medical Association, officers and legislative chairmen of the Indiana State Dental Association, the Indiana State Bar Association, and our own association, on October 9 ate fried chicken, lighted cigarettes and cigars, leaned back in a relaxing mood and informally discussed their mutual problems. Such a meeting had been ordered by the House of Delegates in 1945. Dr. J. E. Ferrell, I.S.M.A. president, sponsored the dinner and directed the discussion. Result of the meeting: each profession learned about the other's legislative objectives, decided each group had much in common, praised the medical profession for sponsoring the get-together, and thought a similar meeting should be held three months hence.

Co-operation a la Huntington. Are you having difficulty getting your members to county society meetings? If so, consider how the Huntington County Medical Society averages a 95 per cent attendance at its meetings. We'll let Dr. Grover M. Nie, the secretary, explain the "Huntington Plan": "When a program of examining high school pupils for physical training began about five years ago we made arrangements with the schools to examine all students at $1.00 each. All physicians in the county society helped. We formed teams and did the exams on Wednesday afternoons, and turned the money into the society treasury. Now each year we examine all freshmen who enter in the fall, and the group that enters in mid-year. All physicians participate. It works fine. We make all meetings dinner meetings at the expense of the society, and have excellent turnouts (95 per cent). It seems to create a spirit of friendliness among the members to hold these exams, and the same is true of the meetings—all held at one of the finest hotels in the state, Hotel Lafontaine."

——ISMA——

Word About Dues. Time to pay dues will soon be here. Now seems an appropriate time to emphasize the importance of prompt payment. State association membership dues are collected with local county society dues. It is obligatory that the county secretary forward the state dues to headquarters office. A member in good standing in the state association (one whose dues are paid) is provided with attorney services in the event he is sued for malpractice. By holding state dues after he has collected them, a county secretary might deprive a physician of this legal help, for unless dues have been received in the state office the member is not eligible to coverage. The By-laws read: "The association shall not undertake the defense of a member . . . in any case in which the member who applies for medical defense by the association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. (Dues are payable on January 1, and become delinquent on February 1 of each year.) The membership card of this association, duly signed and dated by the executive secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this association."

Military News

Dr. Julius C. Travis, Jr., of Indianapolis, has set up an office at 402 K. of P. Building, following his recent release from the Army.

Major Charles A. Reid, of Indianapolis, is now established in his new office, at 2445 Shelby Street, in Indianapolis. Doctor Reid recently received his discharge from the Army.

Captain Chester A. Stayton, Jr., of Indianapolis, is now out of the Army, and on September first he began a residency in radiology at the Veterans Hospital, in Indianapolis.

Captain M. P. Weems, of Jeffersonville, has resumed his practice in Jeffersonville following his recent release from service. Doctor Weems entered the armed forces July 1, 1942, and served for forty-nine months.

Captain Thomas P. Rogers, of Indianapolis, is now stationed at the United States Naval Training Station, in Bainbridge, Maryland. He is in charge of the neuropsychiatric service, and is executive officer to the senior medical officer there.

Dr. Donald Painter has begun the practice of medicine in Cromwell, after serving for two and one-half years with the Army Medical Corps. He was discharged in July, 1946. Doctor Painter is a graduate of the Indiana University School of Medicine.

Discharged from the Army on September 10, 1946, Captain Robert Peacock has established an office in Dunkirk. He graduated from the Indiana University School of Medicine in 1942, and served his internship at the Indianapolis City Hospital and at the Indiana University Medical Center. Doctor Peacock entered the service in May, 1943.

Dr. J. R. Glosson, a native of Rockville, has opened an office for the practice of medicine in Clay City. Doctor Glosson served for two and one-half years with the United States Army, on both the European and Asiatic-Pacific fronts. He graduated from the Indiana University School of Medicine in 1943, and served his internship with the United States Public Health Service in New Orleans, Louisiana.

Dr. Horace Norton, of Plainville, who was recently released from the Army, has established an office for the practice of medicine in Crane, Indiana.

Lieutenant John E. Mackey, of Indianapolis, has been transferred to the Station Hospital at Camp Polk, Louisiana, from Fort Sam Houston, in San Antonio, Texas.

Recently released from the Army, Dr. Rolland Deputy, formerly of Indianapolis, has established a practice in Seattle, Washington, and has transferred his membership there.

Formerly stationed in Martinsburg, West Virginia, Lieutenant Robert J. Lehman, of Indianapolis, is at the present time located at the Mason General Hospital, in Brentwood, Long Island, New York.

Formerly located at the Davis-Mouthan Field, in Arizona, Lieutenant John R. Moriarty, of Indianapolis, is now with the surgical section of the Headquarters of the 15th Air Force, in Colorado Springs, Colorado.

Recently released from active duty with the United States Army, Dr. Robert E. Holsinger, of Fort Wayne, has resumed his practice of medicine and surgery at his former location, 832 East Creighton Avenue, Fort Wayne.

Dr. James Oswalt, of Dunkirk, who was discharged from the Army in March, 1946, with the rank of major, has discontinued his practice there preparatory to doing postgraduate work. He entered the service in 1942.

Captain John H. Alward, of Indianapolis, was separated from the Army on July twenty-third, after thirty-seven months' service. Doctor Alward has accepted a two-year residency in surgery at the City Hospital in Akron, Ohio.

After four years' service in the Army, Dr. Robert E. Bishop, of Orleans, has begun his practice in Indianapolis, where he is associated with Dr. Lester A. Smith, in the Hume Mansur Building. Doctor Bishop received his final discharge from the Army on July thirtieth. His service included two years in the Aleutian Islands, and two years at the Crile General Hospital, in Cleveland.

Discharged only a few months ago, Dr. Bernard W. Cohen, of Indianapolis, has re-enlisted in the Navy and now is stationed at the Naval Air Station, in Livermore, California.

A former member of the United States Army Medical Corps, Dr. Perry Seal has opened an office in Brookville. He served for eighteen months in the European Theatre, and upon his return to the United States he was assigned to a convalescent hospital in Fort Lewis, Washington, until his separation from service.

Dr. Robert J. Byrne has announced the opening of an office for the general practice of medicine in Bicknell. He took his pre-medical training at Indiana University, and graduated from the St. Louis University School of Medicine, in St. Louis, in 1940. He interned at St. Elizabeth's Hospital, in Dayton, Ohio. Doctor Byrne is a veteran of World War II.

Captain Samuel Goldman has announced the opening of an office for the general practice of medicine at 5112 East Michigan Street, in Indianapolis. Doctor Goldman was recently discharged from the Army, after four years of service. He served for twenty-two months in the Pacific Theatre, including New Guinea, the Philippines, and Japan.

After two and one-half years' service with the 93rd Infantry Division, Dr. G. J. Smith has opened an office for the practice of medicine in Kokomo. His service with the Army Medical Corps included two years of service overseas, in the South Pacific. Doctor Smith is a graduate of the Indiana University School of Medicine, in 1942, following which he went into the Army.

Announcement has been made of the appointment of Dr. H. A. P. Leininger to the staff of the Murphy Medical Center, in Warsaw. Doctor Leininger has just completed six years as a surgeon in the United States Army. He is a graduate of the Indiana University School of Medicine, and he interned at the Walter Reed Hospital, in Washington, where he was commissioned in the Medical Corps in 1940.

Following his recent discharge from the Army, Captain J. R. S. Himebaugh, of Indianapolis, has opened an office for the general practice of medicine at Willow Branch. Doctor Himebaugh spent thirty-one months in the service, twenty months of which were spent in the Pacific Theatre, in New Guinea, Leyte, Luzon, and Japan. He served as battalion surgeon with the famed 32nd Infantry Division. Doctor Himebaugh was also stationed at Camp Stewart and at Camp Gordon, in Georgia.

Captain Lewis Pollak, of Indianapolis, who recently was discharged from the Army, is now located at 1602 North Pennsylvania Street, in Indianapolis. Doctor Pollak spent forty months in the service.

Announcement has been made of the opening of an office in Otterbein by Dr. Charles Smith, who was released from the Navy recently. Doctor Smith served a two-year internship at the St. Elizabeth Hospital, in Lafayette, before entering the service.

Separated from the Army after forty-three months' service, Dr. DeWitt W. Brown, of Indianapolis, is now a resident in neuropsychiatry at the Indianapolis City Hospital. A major at the time of his discharge, Doctor Brown spent thirteen months in the Caribbean area, with the 39th Reconnaissance Squadron.

Dr. Thomas O. Middleton, formerly of Ridgeville, has opened an office for the practice of medicine and surgery in Mitchell, following his discharge from the service. He is a graduate of the Indiana University School of Medicine, and he interned at the University of Pittsburgh Medical Center, in Pittsburgh. From there he entered the service with the medical department of the Army Air Corps, with which he served for three years in Japan and Korea. Doctor Middleton's terminal leave expired on August twenty-second.

Released from the Army recently, Dr. Robert W. Vermilya, formerly of Brownstown, has taken over the office and practice of Dr. J. S. Noblitt, in Waveland, who has retired. Doctor Vermilya is a graduate of the Indiana University School of Medicine, and he spent his internship at St. Joseph's General Hospital, in Fort Wayne. His Army service included Walter Reed General Hospital, in Washington, and sixteen months overseas, with the 15th Field Hospital in Italy, and with the 115th Evacuation Hospital.

Major Charles A. Jones, of Franklin, has opened offices in Franklin for the general practice of medicine. Discharged at Camp Atterbury on February 10, 1946, Doctor Jones has taken refresher courses at the Indiana University Medical Center and the Indianapolis City Hospital. He served for forty-four months as a medical officer in the United States Army, and spent twenty-six months in the European Theatre. He was attached to the 78th Division, 65th Medical Regiment, 10th Station Hospital, and the Second Division, which landed on Omaha Beach four days after D-Day. Doctor Jones was wounded on July 3, 1945, while in the battalion aid station of the 310th Infantry. Later, he commanded a platoon of the 47th Field Hospital through Belgium, Germany, and Austria.

Thanksgiving

Our fathers' God! from out whose hand
The centuries fall like grains of sand
We meet today, united, free,
And loyal to our land and Thee,
To thank Thee for the era done,
And trust Thee for the opening one.

Whittier

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Lieutenant Maurice C. Hollingsworth, of Indianapolis, was separated from the service on August twentieth. He spent twenty-three months on sea duty in the Pacific, on the staff of LSM Group II, and at the time of his discharge he was stationed at the Naval Ordnance Plant, in Indianapolis. Doctor Hollingsworth spent a total of more than two years and nine months in the service.

Commander Lester D. Bibler, of Indianapolis, has returned to private practice after a five-year, eight-month service with the Navy. Originally he was attached to the Marine Fleet Force, in San Diego, California, and later he was connected with the 2nd Marine Division, with which he served for sixteen months in the South Pacific. Back in the United States, Doctor Bibler served for sixteen months at Bethesda, Maryland, in addition to tours of duty at the Naval Armory, in Indianapolis, and at the Naval Convalescent Hospital, in Palm Beach, Florida. Doctor Bibler has opened an office at 811 Underwriters Building, in Indianapolis, for the practice of general and internal medicine.

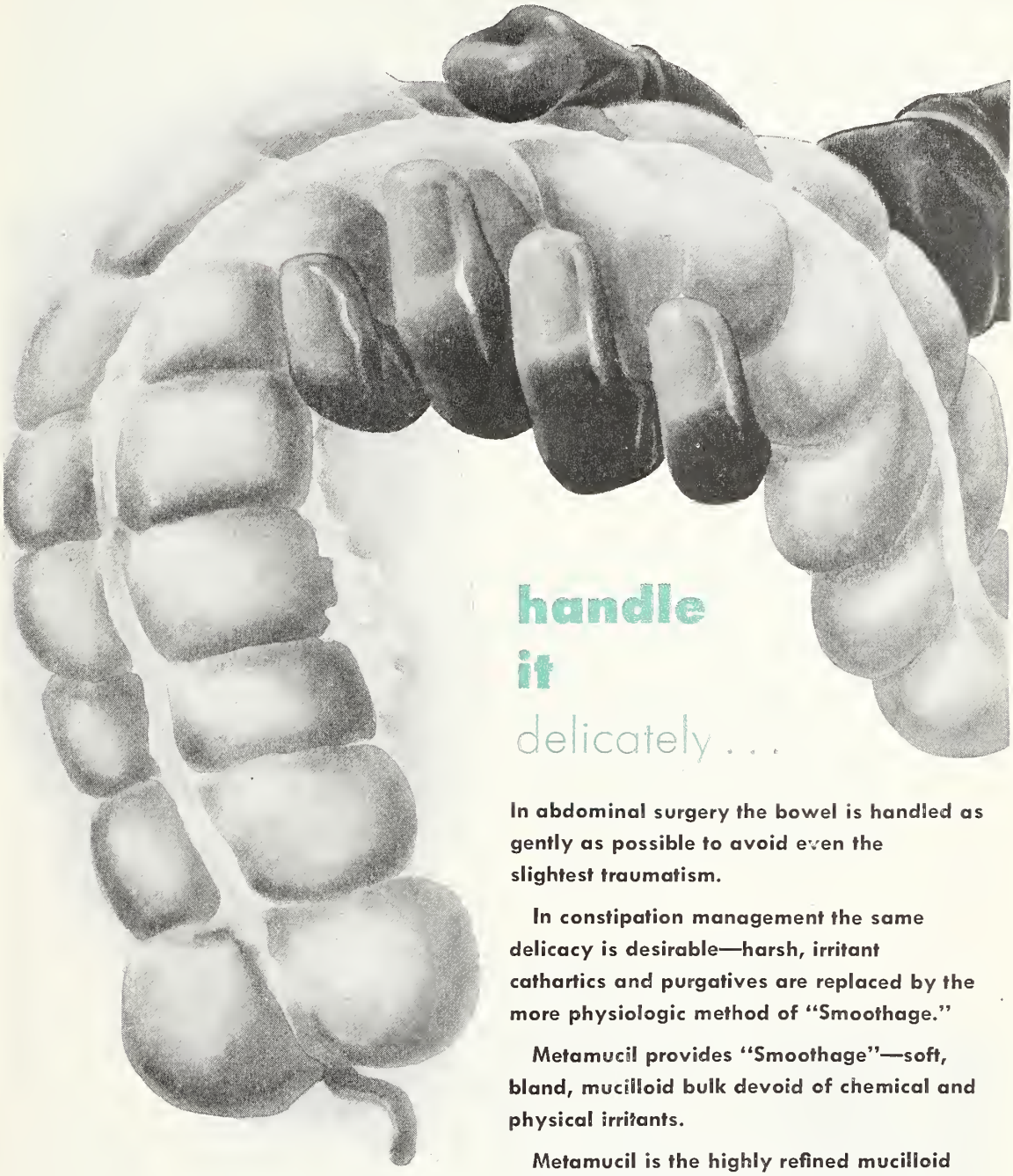
Discharged as a captain, after thirty-two-months' service in the Army, Dr. Alvin T. Stone has announced the establishment of an office at 6202 College Avenue, in Indianapolis, for the general practice of medicine. Doctor Stone served in the Asiatic-Pacific Theatre, where he was battalion surgeon for the 69th Ordnance Battalion. His service in the United States included the Darnall General Hospital, in Danville, Kentucky, and the Mason General Hospital, in Long Island, New York; and he served as psychiatrist at the reception center at Camp Atterbury for one year. Before entering the service Doctor Stone completed a three-year residency at the Methodist Hospital, in Indianapolis.

Separated from service with the rank of colonel, Dr. M. C. Thomas, of Indianapolis, is now located at the Veterans Hospital, in Dayton, Ohio, as chief of the Tuberculosis Unit. Doctor Thomas has a record of more than six years' service with the Army. He was first assigned to the Kentucky Station Hospital, at Fort Knox, where he was chief of the Medical Service and commanding officer of that hospital. Then, as commanding officer of the 140th General Hospital, he went to England, in July, 1944, where this unit was designated as one of three Thoracic Surgery Centers in England. In August, 1945, this unit returned to the United States, and was to have gone to the Pacific, but V-J Day cancelled the trip. Doctor Thomas's final assignment in his military career was that of a medical member of the Disability Review Board, in the office of the Secretary of War, in Washington.

Major Robert S. Bolin, of Elkhart, has informed THE JOURNAL that he has resumed private practice after serving for four years in the Army. Prior to entering the service, Doctor Bolin was located in Goshen, but he is now practicing in Elkhart. He served as chief of the Eye, Ear, Nose, and Throat Department at Camp Atterbury for three years, and then he was transferred to the Darnall General Hospital, in Danville, Kentucky, where he served as chief of the Surgical Service during the remainder of his Army career.

Lieutenant Joseph R. Eastman, Jr., of Indianapolis, received his release from the Navy on August twelfth, at the Great Lakes Naval Training Station. He entered the service in July, 1944, with the Marines. Reporting at the Naval Hospital in Shoemaker, California, Doctor Eastman went overseas immediately, with Marine Aircraft Group 32. With the Marines for about fifteen months, his tour of duty took him to approximately nine islands in the Pacific Theatre. After two weeks' leave at home, Doctor Eastman then was assigned to the Navy, and went to sea on the *U.S.S. Iowa*, which is the largest battleship in the world. The *Iowa* went to Japan shortly after the first of this year as part of General MacArthur's occupation forces. Doctor Eastman's assignment on the *Iowa* lasted approximately ten months, during which time they cruised up and down the west coast, and to Bremerton, Washington, but the greater part of the time was spent around Japan. Doctor Eastman plans to take a residency in pathology at the Indiana University Medical Center, in Indianapolis, in the late fall or the early part of next year.

Major William A. Clunie, of Corydon, was discharged from the service on July twenty-first, and is now on terminal leave. He graduated from the Indiana University School of Medicine in December, 1942, and interned at the Marine Hospital, in Baltimore, Maryland. He entered the service in December, 1943, at Carlisle Barracks, and went overseas in September, 1944, with the 12th Armored Division. Doctor Clunie served as battalion surgeon with this division, which landed at Bournemouth, in southern England. He remained with the 12th Armored Division until after V-E Day, then was transferred to the 129th Evacuation Hospital, on the medical service. In January, 1946, he joined the 39th Medical Battalion, first as executive officer, and later as commanding officer, serving until the end of June, 1946, when the hospital returned to the United States, leaving from Le Havre. The 39th Medical Battalion was stationed at Heilbronn, Germany, and supervised the P.O.W. and Displaced Persons Hospitals. Doctor Clunie was in the 7th Army Territory for approximately five months, with the 12th Army, going through the Rhineland and Central European Campaigns.



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In abdominal surgery the bowel is handled as gently as possible to avoid even the slightest traumatism.

In constipation management the same delicacy is desirable—harsh, irritant cathartics and purgatives are replaced by the more physiologic method of "Smoothage."

Metamucil provides "Smoothage"—soft, bland, mucilloid bulk devoid of chemical and physical irritants.

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News Notes

Dr. George R. Bloom has established an office for the practice of medicine in Elkhart.

Dr. H. D. Tripp, of Plymouth, attended the convocation and scientific assembly of The International College of Surgeons held at Detroit, Michigan, October 20-24, and was one of the group of American surgeons inducted into the college.

Announcement has been made that Dr. Alden J. Rarick, of Cromwell, has joined the staff of the Veterans Administration Hospital, in Nashville, Tennessee.

ANNUAL CLINICAL CONFERENCE

The Third Annual Clinical Conference, sponsored by the Chicago Medical Society, will be held at the Palmer House, in Chicago, on March 4, 5, 6, and 7, 1947. Indiana physicians are cordially invited.

Dr. Paul D. Johnson, of Terre Haute, has been appointed resident physician at the Union Hospital there. Doctor Johnson is a graduate of the Indiana University School of Medicine, and he recently completed his internship at the Indiana University Medical Center, in Indianapolis.

Miss Ethel Joan Mick, daughter of Mr. and Mrs. William E. Mick, of Indianapolis, and Dr. John Richard Scott, son of Mr. and Mrs. Ronald R. Scott, of Indianapolis, were married on September twelfth, at the Meridian Street Methodist Church, in Indianapolis. Doctor Scott graduated from the Indiana University School of Medicine in April, 1946, and is taking his internship at the Indianapolis City Hospital.

Dr. Carl H. McCaskey, of Indianapolis, a past president of the Indiana State Medical Association, was chosen president-elect of the American Academy of Ophthalmology and Otolaryngology at its annual meeting held in Chicago on October sixteenth. He will assume the presidency of the association in 1948.



Carl H. McCaskey, M.D.

Doctor McCaskey has also served as president of the Indianapolis Medical Society; president of the Indiana Ophthalmology and Otorhinolaryngology Societly; and is the chairman of the Department of Otorhinolaryngology of the Indiana University School of Medicine.

A gift of nine hundred fifty dollars has been presented to the Johnson County Memorial Hospital, which is being erected west of Franklin, by the Johnson County Medical Society. The money will be spent in furnishing the physicians' library and locker rooms.

In connection with the Scientific Exhibit on "Cirrhosis of the Liver," presented at the annual session of the Indiana State Medical Association, somehow the name of Dr. Byron W. Kilgore was omitted, and due credit is hereby accorded Dr. Kilgore for his work in this connection.

AMERICAN ACADEMY OF DERMATOLOGY AND SYPHILOLOGY

The fifth annual meeting of the American Academp of Dermatology and Syphilology is scheduled for Cleveland, Ohio, from Saturday, December 7 through Thursday, December 12. This will be the first meeting of the group since December, 1941.

The principal sessions will be held at the Statler Hotel with daily symposia at the Allerton Hotel, and teaching clinics at the Cleveland City hospital Monday, Tuesday, and Wednesday of the convention week. For further information, write to Dr. Earl D. Osborne, 471 Delaware Avenue, Buffalo, New York.

AMERICAN ACADEMY OF ALLERGY

The American Academy of Allergy will hold its annual convention at Hotel Pennsylvania, New York City, November 25-27, inclusive. All physicians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy without payment of registration fee. The program has been arranged to cover a wide variety of conditions where allergic factors may be important. Papers will be presented dealing with the latest methods of diagnosis and treatment as well as the results of investigation and research. Advance copies of the program may be obtained by writing to the Chairman on Arrangements, Dr. Horace S. Baldwin, 136 East 64th Street, New York City, prior to November 10.

PHYSICIANS NEEDED BY VETERANS ADMINISTRATION

The Veterans Administration is in urgent need of physicians for the operation of its tuberculosis units of the veteran's hospitals, particularly in Indiana, Wisconsin, and Illinois.

Numerous positions are immediately available with salaries ranging up to $11,000 per annum, depending upon training and experience. There are opportunities for postgraduate work and individual research.

Applications may be obtained by addressing Dr. Delmar Goode, Branch Medical Director, Veterans Administration Branch Office, No. 7, 226 W. Jackson Boulevard, Chicago 6, Illinois.



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Influenza Virus Vaccine, Types A and B

Refined and Concentrated

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ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

PREPARED from Influenza Virus, Types A and B, propagated in the extraembryonic fluids of the developing chick embryo, concentrated, refined by the red cell elution method, inactivated, and preserved with sodium ethyl mercuri thiosalicylate.

Influenza virus vaccine is one of the outstanding medical contributions of World War II. Likewise, its production in tremendous quantities was one of the war-time contributions of the Pitman-Moore Laboratories.

Following the preliminary investigation of Influenza Virus Vaccine by the Army's Commission on Influenza early in the war, Pitman-Moore Company was one of the first to deliver this vaccine to the armed forces. During and following the war, our laboratories produced hundreds of thousands of doses for military use.

Coincident with the release of the product for civilian use, our laboratories made the first public announcement of its availability to the civilian medical profession.

Supplied in 1 and 5-dose packages



Above: Horvesting the virus-laden extraembryonic fluids from partially incubated eggs, impregnated with influenza virus.

Left: Injecting influenza virus into eggs. During incubation the virus multiplies in the extraembryonic fluids.

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PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

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A. M. A. SCIENTIFIC EXHIBIT

At the Centennial Session of the American Medical Association, to be held in Atlantic City, June 9 to 13, 1947, the Scientific Exhibit will include both the history of medicine during the past century and the latest developments of medical science.

Application blanks for space are now available; all applicants must fill out the regular form. Applications close on January 13, 1947, after which time the Committee on Scientific Exhibit will make its decision and notify the applicants.

Application blanks for space should be procured as soon as possible, from The Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

INDIANA UNIVERSITY NEWS NOTES

Selection of six additional students for admission to the Indiana University School of Medicine this fall has been announced by Dr. John D. VanNuys, executive secretary of the Indiana University School of Medicine.

The freshman class of the Indiana University Medical School now numbers one hundred twenty-eight, which is the maximum number which can be accommodated. Classes in the medical school at Bloomington began October 18.

New members of the class are Jack L. Frye, Muncie; Harold R. Chappell, Oakland City; Thurl C. Burr, Jr., Marion; William H. Cripe, Bedford; M. Porter Murphy, Morgantown; and Fred W. Dierdorf, West Terre Haute.

Deaths

George Milton Buck, M.D., of Bremen, died on August eighth. He was sixty-nine years of age, and was a graduate of the St. Louis College of Physicians and Surgeons, in 1904.

Corwin Richie Price, M.D., of Geneva, died on October third, following an illness of nine months. He was sixty-nine years of age, and had practiced in Geneva since 1905. Doctor Price was a graduate of the Fort Wayne College of Medicine, in 1903, and had limited his practice to ophthalmology.

Ridley Herman Draper, M.D., of Bremen, died on July nineteenth, in St. Augustine, Florida. He was sixty-four years of age. Doctor Draper graduated from the University of Nashville, Tennessee, in 1904, and he was a member of the Marshall County Medical Society, the Indiana State Medical Association, and the American Medical Association.

Robert E. Downing, M. D., of Louisville, Kentucky, formerly of Terre Haute, died on October fifth at Brewton, Alabama. He was forty-one years of age. Doctor Downing formerly practiced in Gary for approximately five years, and then established a practice in Terre Haute. He graduated from the Emory University School of Medicine, in Atlanta, Georgia, in 1930.

Frank Morse Nichols, M.D., of Lagrange, died on September nineteenth, after an illness of four weeks. Doctor Nichols was thirty-seven years of age. He was a graduate of Indiana University School of Medicine, in Indianapolis, in 1934, and had practiced in Warsaw for several years before establishing his practice at Lagrange.

John B. Shipley, M.D., of Hudson, died on July fourteenth, at the age of eighty-four. He graduated from the Curtis Physio-Medical Institute, in Marion, in 1895.

Edson Dorwin Pearson, M.D., of Wabash, died on July twenty-third, at the age of seventy-five. Doctor Pearson was a graduate of the Hahnemann Medical College and Hospital, in Chicago, in 1899.

Jediah H. Clark, M.D., formerly of Connersville, was killed in an automobile accident on September twenty-second, near Macon, Georgia. He was seventy-eight years of age, and had lived in Winter Park, Florida, since his retirement from practice. Doctor Clark graduated from the Medical College of Indiana, in Indianapolis, in 1895.

William J. Laval, M.D., of Evansville, died on June twenty-seventh, at the age of eighty-six. He graduated from the Medical College of Evansville, in 1882, and had retired from practice. He was an honorary member of the Vanderburgh County Medical Society and the Indiana State Medical Association, and was a member of the American Medical Association.

David H. Stern, M.D., of Hammond, died on June thirteenth, at the age of thirty-eight. He was a graduate of the University of Illinois College of Medicine, in Chicago, in 1937, and was a veteran of World War II. Doctor Stern was a member of the Lake County Medical Society, the Indiana State Medical Association, and the American Medical Association.



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It is by such initiative medicine follows the precept of one noted physician, who said, "...We must preserve, first, the Soul of Medicine, and second, Freedom in Medicine."

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SUMMIT NEW JERSEY

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

September 9, 1946.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

News release for general distribution, entitled "Quick Action Often Prevents Crippling When Polio Strikes," was approved.

The following "Hints on Health" column releases were approved:

Week of October 7, 1946—"Arthritis Is Broad Term."

Week of October 14, 1946—"The Effect of Athletics."

WIBC was granted approval to broadcast the A.M.A. health series entitled "Why Worry?" The executive secretary reported that Frank Sharp, manager of WFBM, had been consulted about the request, in view of the fact that his station was now using similar A.M.A. health transcriptions, and that he had expressed no objections.

A pamphlet detailing action by the 79th Congress on Social Security legislation was examined.

LOCAL SOCIETY REPORTS

Delaware-Blackford County Medical Society members held a general business meeting at Hotel Roberts, in Muncie, on September seventeenth. Thirty-one members were present.

Elkhart County Medical Society members met at Hotel Elkhart, in Elkhart, on October third. The guest speaker for the evening was Dr. Frank H. Bethell, Associate Professor of Internal Medicine at the University of Michigan, whose subject was "Treatment of Anemia; Special Reference to Folic Acids." Fifty-five members attended the meeting.

Fort Wayne (Allen County) Society members met at the Chamber of Commerce, in Fort Wayne, on September seventeenth. Dr. Howard Stellner, of Fort Wayne, presented a paper on "Occupational Adjustment of Psychoneurotic Veterans," which was followed by a general discussion of the subject.

Fulton County Medical Society members held their regular monthly meeting at the Woodlawn Hospital, in Rochester, on October fourth.

Hancock County Medical Society members met at the James Whitcomb Riley Hotel, in Greenfield, on October ninth. Speakers of the evening were Dr. Leroy E. Burney, of Indianapolis, and Dr. Walter U. Kennedy, of New Castle. The discussion centered around the county's need for a hospital.

Hendricks County Medical Society members held a meeting at Canterbury College, in Danville, on September twentieth. Delegates to the state association were elected, and it was decided to hold regular monthly meetings on the first Tuesday of each month, the place for the meetings to be selected later.

The members held another meeting at the Crawley Restaurant, in Danville, on October first. The society approved the sponsorship of a mass chest x-ray program, which is made available by the Indiana State Board of Health and the United States Public Health Service. They also adopted a resolution sponsoring a Hendricks County Hospital, and appointed delegates to confer with the county commissioners.

Howard County Medical Society members held a meeting at the St. Joseph Memorial Hospital, in Kokomo, on October fourth. Twenty-five members attended the meeting, which was addressed by Dr. Bernard D. Rosenak, of Indianapolis, whose subject was "Diseases of the Liver."

Indianapolis (Marion County) Medical Society members met at the White Cross Service Center, at the Methodist Hospital, in Indianapolis, on October first, when case reports were presented by Drs. Donald E. Wood, Gordon W. Batman, John V. Thompson, and M. H. Mentendiek, all of Indianapolis.

At another meeting, on October eighth, Dr. J. A. Toomey, Department of Public Health and Welfare, Cleveland, Ohio, discussed "Poliomyelitis."

"Early Treatment of Poliomyelitis" was the title of a paper presented by Dr. William T. Green, Professor of Orthopedic Surgery, Harvard Medical School, Boston, Massachusetts, at a meeting of the society on October fifteenth.

At the meeting held on October twenty-second, a paper was read by Dr. Arlie R. Barnes, of the Section of Cardiology, of the Mayo Clinic, Rochester, Minnesota.

Warrick County Medical Society members held a meeting in Boonville, on September tenth. The eight members who were present discussed the progress of the county hospital project.

PALATABILITY AND NUTRITION FACTORS of Campbell's STRAINED BABY SOUPS



Q. What is the importance of palatability?

A. A leading pediatrician has pointed out that even in the early months of life infants are able to detect minute differences in flavor. The appealing palatability of Campbell's Strained Baby Soups is, therefore, an advantage. It should further be pointed out that all the "tastes" in these soups are the wholly natural ones of the meats, vegetables and cereals used.

Q. Why are the different ingredients selected?

A. Campbell's Strained Baby Soups are planned to provide a balance in nutrients to supplement the daily milk diet. Since it takes many different foods to supply the approximately 40 nutrients needed for infant development and energy, we use vegetables and a cereal in preparing each of the four meat soups. Flavor is improved, too. For instance, liver alone has too strong a taste for some babies, but blended with vegetables, palatability is enhanced. It should also be noted that these soups are intended for use as early in normal infancy as any other strained baby foods.

Q. What measures are taken to conserve food constituents?

A. In preparing these Baby Soups, Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins.

A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

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Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . *and in good flavor.* Every resource of Campbell's Kitchens is devoted to that aim.

LOOK FOR THE RED-AND-WHITE LABEL

Lake County Medical Society members held a meeting at the Methodist Hospital, in Gary, on September twelfth. They were addressed by Dr. Charles L. Spurr, of the University of Chicago School of Medicine, on the progress of medical science experiments with radio-active therapy—an atom by-product. Dr. C. W. Eisele, who is also from the University of Chicago School of Medicine, addressed the group on "Brucellosis."

Parke-Vermillion County Medical Society members met at the Turkey Run Inn on September twenty-fifth, with eleven members present. Dr. James M. Kirtley, of Crawfordsville, discussed "Toxemia of Pregnancy."

Shelby County Medical Society members began their 1946-47 season with a dinner meeting at the Kopper Kettle, at Morristown, on September eleventh. Wives of members attended. The speaker was Thomas A. Hendricks, of Chicago, secretary of the Council on Medical Service, American Medical Association, whose subject was "Public Relations."

Vanderburgh County Medical Society members met at Hotel McCurdy, in Evansville, on October eighth. The eighty-eight members who were present heard Dr. Andrew B. Jones, of St. Louis, Missouri, discuss "The Management of Neuroses in General Practice."

WOMAN'S AUXILIARY to the Indiana State Medical Association

President: Mrs. S. J. Petronella, East Chicago.
President-elect: Mrs. A. W. Ratcliffe, Evansville.
Corresponding Secretary: Mrs. David Eisenberg, Hammond.
Treasurer: Mrs. Wendell Kelly, Anderson.
Press and Publicity: Mrs. O. H. Bakemeier, Indianapolis.

CLARK AND FLOYD COUNTIES

Mrs. S. J. Petronella, state president of the Woman's Auxiliary to the Indiana State Medical Association, was honor guest at a luncheon given by the Clark and Floyd County Medical Auxiliaries, at the Pendennis Club, in Louisville, Kentucky, in September.

DELAWARE-BLACKFORD COUNTY

The Woman's Auxiliary to the Delaware-Blackford County Medical Society held its first meeting in September, at Shady Oaks, with a dinner. Approximately fifty members attended this meeting. A short business session was held, with Mrs. William Quick, the new president, presiding. Miss Josephine Clevenger gave a talk on The Harry Mock School.

ELKHART COUNTY

Mrs. J. S. Slabaugh, of Nappanee, was hostess for the Woman's Auxiliary to the Elkhart County Medical Society on Thursday, October third. Mrs. L. M. Slabaugh, the president, was in charge. Following the business meeting, Mrs. R. C. Chapman, of Nappanee, guest speaker, talked on South American customs.

LAKE COUNTY

The Hammond Woman's Auxiliary to the Lake County Medical Society held its first fall meeting at Penn Oaks, farm-home of Dr. and Mrs. P. Q. Row, with a potluck supper, on October first. Mrs. David Eisenberg, president, presided.

The Woman's Auxiliary to the Lake County Medical Society held its meeting at Peter Levent's, with a board meeting at 5:00 P.M., and dinner at 6:00 P.M., on October tenth.

MARION COUNTY

Collection of samples of drugs from the offices of Indianapolis physicians by the members of the Woman's Auxiliary to the Marion County Medical Society resulted in forty-six cartons of supplies for overseas hospitals beset by shortages of all kinds. The supplies, packed at the Red Cross Chapter House, were sent to the Medical and Surgical Relief Committee, in New York, and forwarded to the foreign hospitals. This is the Auxiliary's project for the year 1945-1946, and is headed by Mrs. Russell J. Spivey, special projects chairman.

A musical program and tea, honoring new members, will be the Marion County Medical Auxiliary's opening meeting of the fall season, at the D.A.R. Chapter House on November twelfth. Mrs. Reid Keenan, first vice-president, will have charge of the meeting, assisted by the Membership, Hospitality, and Social Committees.

THE ANNUAL CLINICAL CONFERENCE OF THE CHICAGO MEDICAL SOCIETY

will be held at the Palmer House, March 4, 5, 6, and 7, 1947.
Plan now to attend this instructive meeting.

Make your hotel reservations early to avoid disappointment.



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COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY	SECRETARY	TIME OF MEETING
Adams	John C. Carroll, Decatur	Second Tuesday of each month.
Allen (Ft. Wayne)	O. J. Miller, Fort Wayne	1st and 3rd Tuesdays except June, July and August.
Bartholomew	Byron K. Zaring, Columbus	Last Wednesday evening of each month.
Benton	L. P. Muller, Boswell	First Monday of each month.
Boone	C. G. Kern, Lebanon	First Tuesday of each month.
Carroll	Charles Wise, Camden	Second Thursday of each month except June, July, August.
Cass	Will W. Holmes, Logansport	Third Friday of each month.
Clark	J. T. Carney, Jeffersonville	Second Tuesday evening of each month.
Clay	John M. Palm, Brazil	Second Tuesday of each month.
Clinton	T. A. Dykhuizen, Frankfort	First Tuesday night of each month.
Crawford	H. H. Deen, Leavenworth	Dates of meetings variable.
Daviess-Martin	A. G. Blazey, Washington	Fourth Tuesday of each month.
Dearborn-Ohio	J. C. Elliott, Guilford	Last Thursday of each month except July, August.
Decatur	H. S. McKee, Greensburg	Third Wednesday of each month.
DeKalb	Harold Nugen, Auburn	Every third month. (A called meeting.)
Delaware-Blackford	Bruce W. Stocking, Muncie	Third Tuesday of each month.
Dubois	P. J. Blessinger, Jasper	Quarterly.
Elkhart	O. E. Wilson, Elkhart	First Thursday of each month except June, July, August.
Fayette-Franklin	R. H. Elliott, Connersville	Second Tuesday of each month.
Floyd	Phillip Cohn, New Albany	Second Friday of each month.
Fountain-Warren	A. R. Kerr, Attica	Variable.
Fulton	A. E. Stinson, Rochester	First Friday of each month.
Gibson	H. H. Alexander, Princeton	Second Monday of each month, except July, August.
Grant	R. W. Lavengood, Marion	Fourth Thursday of each month.
Greene	George Moses, Worthington	First Thursday following second Monday of each month.
Hamilton	Robert F. Harris, Noblesville	Second Tuesday each month except July, August.
Hancock	Joseph L. Allen, Greenfield	Second Wednesday of each month.
Harrison	W. E. Amy, Corydon	Second Wednesday of each month.
Hendricks	W. T. Lawson, Danville	
Henry	R. D. Spindler, New Castle	Third Thursday of each month.
Howard	Joe D. Boughman, Kokomo	First Friday of each month.
Huntington	G. M. Nie, Huntington	First Tuesday of each month.
Jackson	Geo. H. Kamman, Seymour	Third Friday of each month.
Jasper-Newton	W. G. Pippenger, Brook	Second Friday every second month.
Jay	H. Frederick Streib, Portland	First Friday of each month.
Jefferson	O. A. Turner, Madison	Fourth Monday of each month.
Jennings	John H. Green, North Vernon	Last Wednesday of each month.
Johnson	Helen Barnes, Greenwood	On call of president.
Knox	C. L. Boyd, Vincennes	Third Tuesday of each month.
Kosciusko	L. A. Laird, North Webster	Second Tuesday of each month.
LaGrange	Alfred Wade, Howe	First Thursday of each month.
Lake	H. M. Baitinger, Gary	Second Thursday of each month.
	Exec. Sec.: Mr. Rollis Weesner	504 Broadway, Gary.
LaPorte	R. W. Kepler, LaPorte	Third Thursday of each month.
Lawrence	Roland E. Wynne, Bedford	First Wednesday of each month.
Madison	M. A. Austin, Anderson	Third Monday of each month except June, July, August.
Marion (Indianapolis)	Frederic W. Taylor, Indianapolis	Every Tuesday evening.
Marshall	L. W. Vore, Plymouth	First Wednesday of each month except July and August.
Miami	R. E. Barnett, Peru	Last Friday of each month except July and August.
Monroe	Abraham M. Owen, Bloomington	Last Wednesday of each month.
Montgomery	Wemple Dodds, Crawfordsville	Third Thursday evening of each month except July and Aug.
Morgan	R. W. Van Bokkelen, Mooresville	Third Wednesday evening of each month.
Noble	Frank W. Messer, Kendallville	Quarterly.
Orange	C. E. Boyd, West Baden Springs	Second Tuesday every other month.
Owen	Julia S. Thom, Spencer	Third Friday of each month.
Parke-Vermillion	R. S. Bloomer, Rockville	Third Wednesday of each month.
Perry	D. A. Dukes, Tell City	Tuesday before last Thursday of each month.
Pike	L. R. Miller, Winslow	Second Tuesday of each month.
Porter	John R. Frank, Valparaiso	Last Tuesday of each month, 8:00 p.m.
Posey	J. R. Ranes, Mt. Vernon	Second Tuesday each month, except June, July, August.
Pulaski	T. E. Carneal, Winamac	Last Tuesday night of each month.
Putnam	Dick J. Steele, Greencastle	Second Thursday of each month from September through June.
Randolph	Wayne Harmon, Lynn	Second Monday night of each month.
Ripley	R. Lee Smith, Osgood	First Wednesday of each month.
Rush	R. B. Johnson, Rushville	Second Thursday of each month.
St. Joseph	Kenneth L. Olson, South Bend	Second and fourth Tuesday of each month except dinner meetings held fourth Wednesday.
	Exec. Sec.: Mr. Harry Davis	509 City National Bank Bldg., South Bend.
Scott	J. P. Wilson, Scottsburg	Third Tuesday of each month.
Shelby	D. B. Silbert, Shelbyville	Second Wednesday evening of each month.
Spencer	John H. Barrow, Dale	Called.
Starke	J. F. DeNaut, Knox	Fourth Friday of each month.
Steuben	Donald Creel, Angola	Last Friday of each month.
Sullivan	J. S. Brown, Carlisle	First Wednesday of each month.
Switzerland	L. H. Bear, Vevay	First Monday of each month.
Tippecanoe	J. C. Burkle, Lafayette	Second Tuesday evening of each month except July, August.
Tipton	W. A. Kurtz, Tipton	First Tuesday of each month.
Vanderburgh	W. O. Denzer, Evansville	Second Tuesday of each month.
Vigo	A. M. Mitchell, Terre Haute	Second Tuesday of each month except June, July, August.
Wabash	J. T. Steffen, Wabash	First Wednesday of each month except July and August.
Warrick	Ralph E. Zwickel, Newburg	Second Wednesday of each month.
Washington	I. E. Huckleberry, Salem	First Wednesday of each month.
Wayne-Union	Harry P. Ross, Richmond	Second Thursday of each month.
Wells	H. Brooks Smith, Bluffton	Third Monday of each month.
White	Henry W. Greist, Monticello	Last Friday of each month.
Whitley	O. F. Lehmberg, Columbia City	Second Tuesday of each month.



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DELEGATES TO THE A.M.A.

For One Year (term expires Dec. 31, 1946): H. G. Hamer, M.D., Indianapolis; A. S. Giordano, M.D., South Bend. Alternates: Karl R. Ruddell, M.D., Indianapolis; George Collett, M.D., Crawfordsville.

For Two Years (term expires Dec. 31, 1947): Don F. Cameron, M.D., Fort Wayne; F. S. Crockett, M.D., Lafayette. Alternates: Norman M. Beatty, M.D., Indianapolis; A. M. Mitchell, M.D., Terre Haute.

COUNCILORS

District	*Councilor*	*Term Expires*
1	I. C. Barclay, Evansville	Dec. 31, 1947
2	James H. Crowder, Sullivan	Acting
3	A. P. Hauss, New Albany	Dec. 31, 1946
4	Charles F. Overpeck, Greensburg	Dec. 31, 1947
5	A. M. Mitchell (Chairman), Terre Haute	Dec. 31, 1948
6	W. U. Kennedy, New Castle	Dec. 31, 1946
7	Cyrus J. Clark, Indianapolis	Dec. 31, 1947
8	E. H. Clauser, Muncie	Dec. 31, 1948
9	Wemple Dodds, Crawfordsville	Dec. 31, 1946
10	William H. Howard, Hammond	Dec. 31, 1947
11	C. S. Black, Warren	Dec. 31, 1948
12	A. Jerome Sparks, Fort Wayne	Dec. 31, 1946
13	Alfred Ellison, South Bend	Dec. 31, 1947

OFFICERS OF COUNCILOR DISTRICTS—1946

District	*President*	*Secretary*	*Place and date of meeting*
1	A. F. Marchand, Haubstadt	George Willison, Evansville	
2	K. L. Hull, Bloomfield	J. S. Brown, Carlisle	
3	Claude Dollens, Oolitic	Roland E. Wynne, Bedford	
4	R. B. Hart, Columbus	Lowell P. Beggs, Columbus	
5	J. F. Spigler, Terre Haute	M. C. Topping, Terre Haute	
6	Will A. Thompson, Liberty	Perry A. Campbell, Richmond	Richmond, May 8, 1947
7	O. T. Scamahorn, Pittsboro	Horace M. Banks, Indianapolis	Danville (Date to be decided later)
8	Bruce W. Stocking, Muncie	Anson Hurley, Muncie	
9	Charles O. Weddle, Lebanon	John R. Porter, Lebanon	
10	L. J. Danieleski, Gary	M. B. Gevirtz, Hammond	
11	Max R. Adams, Flora	O. G. Brubaker, North Manchester	
12	C. E. Munk, Kendallville	G. T. Bowers, Fort Wayne	
13	R. A. Fargher, LaPorte	O. E. Wilson, Elkhart	

INFORMATION FOR CONTRIBUTORS TO THE JOURNAL

All articles must be typewritten, double-spaced, on one side of white paper, with margins of at least one inch.

Photographs should be printed on glossy paper. Negatives are not acceptable.

Only a limited number of illustrations can be used with each original article. If an excessive number are submitted for publication, the cost of extra illustrations must be borne by the author.

Contributors are responsible for all statements made in their articles. The editor and editorial board members may not be in agreement with various views expressed by authors, but it is desired to allow authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication only with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association. All communications regarding advertising and subscriptions should be sent to THE JOURNAL of the Indiana State Medical Association, 1017 Hume Mansur Building, Indianapolis 4, Indiana. Communications dealing with editorial matters should be sent to E. M. Shanklin, M.D., Editor, 5141 Hohman Avenue, Hammond, Indiana.



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Left: Injecting influenza virus into eggs. During incubation the virus multiplies in the extraembryonic fluids.

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THE DIFFERENTIAL DIAGNOSIS OF THE ACUTE ABDOMEN*

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CHICAGO, ILLINOIS

The subject of the acute abdomen is a trite one. Although articles and treatises have been written about it for decades, the diagnostic difficulties still remain numerous. I have examined charts from all the surgical services at the American and Cook County Hospitals for a period of the last five years, the purpose being to determine which diseases are most frequently mistaken in the acute abdomen. To my surprise I did not find fifty or seventy-five conditions which confuse us, but rather six outstanding ones that we mistake most frequently. These six conditions are: acute gall bladder disease, acute appendicitis, perforated peptic ulcer, renal colics, acute hemorrhagic pancreatitis, and coronary occlusion. There is a seventh disease which deserves special consideration; that is salpingitis. Acute or chronic salpingeal pathology is frequently associated with a perihepatitis which produces pseudo-gall bladder pain. Because of this, gall bladder explorations and surgery have been done, in cases of salpingitis, resulting in danger to the patient and embarrassment to the surgeon.

To make a diagnosis one must have a definite plan in mind. Our plan consists of four headings, namely: history, present symptom complex, physical examination, and laboratory data. This simple plan has served us well and we utilize it daily.

Acute Cholecystitis: The dictum that certain types of people get certain types of diseases seems to be correct. The gall bladder type is described as being fair, fat, and forty. The patient is usually a female in the latter third or fourth decade, and somewhat obese. There is always an exception to the rule; hence, the most fulminating hydrops of the gall bladder on our service was seen in a young, thin boy of sixteen. The age of forty is related to a previous history of pregnancy, and this is theoretically explained in the following way: the average female has her children in the second decade of life. While pregnant she develops a physiologic hypercholesterolemia; some of this cholesterol deposits on the mucous membrane of the gall bladder in the form of polypi. These break off and form the nuclei for stones. It takes from ten to twenty years for gall stones to attain any appreciable size, so that by the time she reaches her fourth decade the stone is large enough to obstruct or irritate. Nulliparous women may have gall stones or gall bladder disease, but this, too, is the exception and not the rule.

It is important to determine the history of a previous attack of pain. The usual disease in the middle aged female that will produce an attack of pain so severe that the physician must administer a sedative is an acute gall bladder, until proved otherwise. It is unnecessary to administer morphine to a case of acute appendicitis; renal colics will be differentiated presently, and coronary occlusion is rare in the female. One of the most unusual lesions noted in the female is a perforated peptic ulcer. The gall bladder patient also presents a previous history of "selective dyspepsia." By this we mean that there are certain specific foods that the patient cannot digest. There are four primary offenders to these foods. They are fried and fatty foods, raw apples, cucumbers, and cabbage. The patient does not use the term "dyspepsia," but describes this as the two "B's"; namely, bloating and belching. In other words a specific food has produced a specific symptom complex. To summarize and describe the gall bladder patient one may use an alliteration and state that she is the patient with the seven "F's": she is the Fair, Fat, Fertile, Flatulent, Flabby, Female of Forty.

The complaint is one of pain. It is important to determine what kind of pain is present; a constant pain is due to edema, but colicky pain is caused by obstruction. This is one of the factors which indicate whether the case should be treated conserva-

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tively or surgically. It is unwise to treat an obstructed lesion conservatively since these are cases which result in early gangrene and perforation. Morphine should not be used in gall bladder disease because it is a smooth muscle contractor, and since the gall bladder is a smooth muscle organ we should not administer a medicament which would stimulate its activity. By increasing muscle tonus, morphine may actually aggravate or provoke gall bladder pain and colic. One should not state, however, that the drug must never be used in gall bladder disease, since it still has its place, namely, to prevent shock. These patients are treated first with nitrite therapy. One breaks an amyl nitrite bead and lets the patient inhale the vapors; 1/100th grain of nitroglycerin is placed under the tongue, and 3 grains of sodium amytal or any other barbiturate is given by mouth. If this gives no relief we administer a hypodermic which consists of 1/20th of a grain of dilaudid and 1/100th of a grain of nitroglycerin; the nitroglycerin counteracts the contractile power of dilaudid. Should these measures fail, antispasmodic therapy with such drugs as papaverine, demerol, et cetera, is tried. Morphine is used only after all other measures have been utilized.

Gall bladder pain is usually located under the right costal margin, but may be referred along the path of the splanchnic nerves which supply the stomach. The stomach responds to this stimulus in one of three types of gastric spasms: (1) pylorospasm; (2) mid-gastric spasm; (3) cardiospasm. If a pylorospasm is produced the gall bladder condition might be confused with peptic ulcer; if mid-gastric spasm results a stomach carcinoma may be erroneously diagnosed; and if associated with cardiospasm, the pain appears on the left (pseudo-coronary pain) and coronary disease may be wrongly considered.

Referred pain should not be confused with radiation of pain. By radiation we mean that gall bladder pain, located under the right costal margin, radiates along the path of the seventh intercostal nerve to the inferior angle of the right scapula, or interscapular. Gall bladder pain, therefore, cannot radiate to the right shoulder. Shoulder pain is an entirely different mechanism which involves the phrenic nerve and is indicative of peritonitis. When a gall bladder patient has true shoulder pain a diagnosis of gangrenous or ruptured gall bladder with biliary peritonitis should be made.

Temperature, pulse, and respiration are included under the heading of physical examination. The patient with an acute gall bladder has an early high fever; hence, a temperature of 102° is not unusual in the first twelve to twenty-four hours of acute cholecystitis. The early fever is explained by the absence of a submucosa. Since this tough, resisting layer is lacking, there is greater chance for early contamination and absorption in the peritoneal cavity. The patient has a pulse which is increased according to the temperature; therefore, for every degree rise in fever there will be approximately a ten beat increase in pulse rate. Respirations are slightly increased because breathing is painful. This is due to the fact that the inflamed gall bladder rubs against the sensitive parietal peritoneum; because of this, acute gall bladder disease may be confused with pneumonia or pleurisy.

Although pain, a symptom, may be referred anywhere along its nervous path, tenderness, a physical finding, remains at the site of pathology. This is an excellent diagnostic rule having few if any exceptions. The tenderness of gall bladder disease will be located in the region of the right costal margin. If it is most marked on a level with the umbilicus; it may be difficult to determine whether the condition is an inflamed, low-lying gall bladder or an acute retrocecal appendix. There are two ways which aid in the differentiation of these two conditions. First, we recall that the normal abdomen reveals a tympanitic note to percussion in all four quadrants. If the tenderness opposite the umbilicus is due to an inflamed gall bladder we assume that the organ is unusually large or that a ptotic liver is present with an inflamed gall bladder at its free border. This would cause an obliteration of the normal tympany in the right upper quadrant; in its place the percussion note would be one of dullness or flatness. If the tenderness on the level with the umbilicus retains normal tympany in the right upper quadrant, this would point to a high-lying retrocecal appendix. Another method of differentiating the gall bladder and appendix is by means of Ligat's Test. This test locates areas of hyperesthesia over an inflamed organ. If the tenderness is due to gall bladder disease an area of hyperesthesia, which is elicited by picking up the skin and letting it drop, is present from the umbilicus upwards to the right costal margin. If the tenderness is due to an acute appendix, the area of hyperesthesia will be found from the umbilicus down to Poupart's ligament.

A rectal examination is done as a routine in every physical examination. More important than the rectal or vaginal examination is a so-called bidigital, which is conducted by placing the index finger in the vagina and the middle finger in the rectum, with the perineum in between. This will immediately orient the examiner so that adnexal pathology is discovered.

The laboratory data usually consists of a white blood count and a urinalysis. More important than the white blood count or urinalysis is a differential blcod count. This is easy to do and more accurate than the total count. If the "poly" count is high, we assume that an acute infectious process is present; a high "poly" count in the presence of a low white count means a poor prognosis. The urinalysis may be misleading; a few red cells do not clinch the diagnosis as one of renal pathology. A negative urine has been found with a renal stone completely blocking the ureter so that no blood or pus could pass into the bladder.

A flat x-ray plate in every acute abdominal condition is a good routine. In this way one may determine whether a calcified gall bladder or visible

stones are present. It also gives an indication whether or not the liver is enlarged or ptotic.

Acute Appendicitis: The more we see of acute appendicitis, the more we respect the condition. The statement, "only an appendix," is indeed a dangerous one. This condition is most frequently found in individuals under the age of forty and is somewhat more common in males. It will be recalled that gall bladder conditions appear most frequently after the age of forty. The story the patient relates is a very stereotyped and definite one. To put it in his language: "Something I ate gave me a belly ache." This is his way of describing acute epigastric distress. When he gets his "belly ache" he usually seeks the advice of a druggist who accommodates him with a cathartic, or some well-meaning friend who suggests an enema. Within the first twenty-four hours his "belly ache" becomes a soreness low on the right side. His acute epigastric distress has become localized to the right lower quadrant. The "two-question test" is both useful and time-saving. Question No. 1: "Where was your pain when it started?"; to this interrogation the patient points to his entire abdomen. Question No. 2: "Where does it hurt you now?"; he then points to the right lower quadrant, usually McBurney's point. This simple method of having the patient demonstrate diffuse pain which localizes will diagnose the vast majority of cases of acute appendicitis.

Nausea and vomiting have been impressed upon us as being associated with appendicitis. This is the exception and not the rule. Anorexia, or loss of appetite, is more constant and more important than either nausea or vomiting. Anorexia, nausea, and vomiting are three degrees of one symptom; anorexia is the mildest form and is due to microscopic distention of the appendix; nausea, the middle degree, is due to moderate distention; and vomiting, the maximum degree, is found in greatly distended appendices. The most common symptom in acute appendicitis is anorexia, and if the patient states that his appetite is not gone we doubt the diagnosis of acute appendicitis. Two complaints which are extremely rare in acute appendicitis are diarrhea and chills. These are probably found in less than one per cent of the cases. Constipation is the rule, and the patient usually states that his A.M.—B.M. was lacking the morning of the attack.

Fever is not an early finding in acute appendicitis; in fact, if present it is suggestive of peritoneal soiling. It is true that cases of acute appendicitis have a fever of 102° or 103°, but these are no longer cases of appendicitis; they are cases of far-advanced peritonitis. If appendices could be operated upon when the temperature is below 99° the mortality would be very low.

Acute appendicitis does *not* give right rectus rigidity. Although the reverse is taught in most schools and text books, the point should be clarified. It is impossible for an individual to contract his right rectus muscle without contracting the left; therefore, when pressure is made upon an inflamed area, both rectus muscles contract. This is not a hair-splitting point, but rather an important differentiation. When only one rectus is rigid we conclude that an underlying mass, such as a tumor or abscess, has produced this phenomenon. When both recti contract to pressure we refer to this as "muscular defense" rather than right or left rectus rigidity. The importance of this is stressed when we realize that diagnosis, treatment, and prognosis may depend upon the presence of right rectus rigidity or simple muscular defense.

The iliopsoas and obturator signs do not diagnose acute appendicitis; they locate an acute appendix. Probably a misconception has arisen because these signs are usually discussed under the heading of acute appendicitis; they may, however, be produced in other diseases. The right iliopsoas sign is elicited by placing a patient on his left side and hyperextending the right leg. If positive, pain is produced over the iliopsoas fascia which will be manifested in the region of the right lower quadrant. In the presence of a history of acute appendicitis this would signify that the appendix is overlying the iliopsoas fascia and is retrocecal. The obturator sign will locate a pelvic appendix. It is conducted in the following way: with the patient on his back the thigh is flexed upon the abdomen and the leg upon the thigh; the leg is then abducted. This causes internal rotation of the thigh and stretches the obturator internus muscle. If this produces pain it is diagnostic of a fascitis involving the obturator fascia, which can be caused by an inflamed tube, appendix, or ovarian cyst. If the patient elicits a history of acute appendicitis with a positive obturator sign we conclude that the appendix is low-lying and in the pelvis. Rovsing's sign is also helpful. It is elicited by pressing over the left lower quadrant. If there is an inflammation of the appendix and the cecum, the colonic gas which has been pushed to the right will produce pain over the cecal region. It is quite diagnostic of acute appendicitis and is found in sixty to seventy per cent of such cases.

Routine rectal or bi-digital examinations are done; at times an acute appendix or appendiceal mass may be felt. Late and neglected appendices may produce a pelvic abscess which points rectally or vaginally, and this examination reveals the proper site for incision and drainage.

The laboratory tests are routine.

Perforated Peptic Ulcer: This condition is rare in females. Usually a previous history of peptic ulcer or gastric hemorrhage can be obtained; however, the perforation may be the very first complaint.

The present history reveals that after eating the patient was seized with a sudden pain which doubled him up. Regardless of what he might be doing, he immediately stops or actually drops to the floor. The classical picture of perforated peptic ulcer with board-like rigidity and a shock-like syndrome is too well known to bear repetition. Two signs which should be sought for in every perforated peptic ulcer are the findings with aus-

cultation of the abdomen, and the presence of a pneumo-peritoneum. Auscultation reveals an absolutely silent abdomen when an ulcer perforates, leaks, and soils the peritoneal cavity. This is not new since the late J. B. Murphy has stressed its importance many decades ago. We fear making a diagnosis of perforated peptic ulcer in the presence of intestinal sounds. There are exceptions, and one of these will be discussed presently under the subject of forme fruste ulcer. The next sign which helps clinch the diagnosis is the demonstration of a spontaneous pneumoperitoneum. Normally a magenblase or stomach air bubble is present. When the ulcer perforates this air bubble sneaks out of the stomach and into the general peritoneal cavity. It can be demonstrated either by percussion or with the fluoroscope. Fluoroscopy is by far the more accurate. The patient is placed on his left side so that the free air bubble may gravitate upward between the liver and the right leaf of the diaphragm. By so doing the liver is displaced downward and separated from the diaphragm. Normally the liver hugs the diaphragm and no air space is visible between them. If this air is of an appreciable amount, it obliterates liver dullness with a replacement by tympany to percussion. The sign is easy to demonstrate, quite pathognomonic of perforated peptic ulcer, and present in about seventy per cent of all cases.

The forme fruste ulcer deserves special mention. The term refers to a pin-point perforation in the stomach or duodenum which is immediately sealed over by muscular contraction or the overlying liver. Therefore, the spillage is minimal and the amount of peritoneal soiling small. This patient may experience a sudden sharp pain in his epigastrium, but the typical physical findings are lacking. He may be able to straighten out and walk about. Abdominal sounds may be present and the magenblase still intragastric, having had no chance to leave the small perforation. These patients present a rather misleading picture and have been misdiagnosed; however, with the ingestion of their next meal they usually re-perforate and present the typical picture.

The temperature, pulse, and respirations will depend upon whether or not shock is present. Most perforated peptic ulcers go into a preliminary shock which varies in its intensity. The shock associated with perforated ulcers responds rapidly to therapy. Within a few hours, however, the classical picture of peritonitis develops with the associated increase in temperature, pulse, and respiratory rate.

The contents from a perforated ulcer may pass downward, along the so-called "paracolic gutter of Moynihan," pool around the appendix, and produce exquisite tenderness at McBurney's point. This patient may then reveal a history of epigastric distress with localization to the right lower quadrant which would be quite suggestive of an acute appendix. Upon exploratory operation, free fluid will be found in the peritoneal cavity with all signs of a peritonitis, and a red and injected appendix seen and removed. These patients usually die if the leaking ulcer is overlooked. This catastrophe can be avoided if somebody in the operating room opens the appendix, before closure of the abdomen is instituted, and exposes a normal mucous membrane. We have been taught that acute appendicitis starts on the mucous membrane and travels outward; therefore, when we find serosal involvement with a normal mucous membrane we look elsewhere for the cause of the peritonitis and usually find a perforated peptic ulcer.

Laboratory data includes the flat x-ray plate which has been discussed under the subject of spontaneous pneumoperitoneum. A routine blood count and urinalysis is done. Some of these patients might have bled, and although perforated ulcers are known not to produce massive hemorrhage, signs of a secondary anemia may be present.

Acute Pancreatitis: It is important to recall that this disease may appear in one of two forms; either acute edematous pancreatitis or hemorrhagic pancreatitis. The former presents a mild clinical picture, but the latter which is associated with fat necrosis and occasionally a hemorrhagic peritonitis produces a fulminating one. The acute edematous form usually recovers without therapy, but the hemorrhagic pancreatitis requires surgical intervention. It is the hemorrhagic type, therefore, which is important to diagnose and treat promptly.

The patient who develops acute pancreatitis resembles the gall bladder patient; hence, the condition is more common in females, rarely occurring before the age of forty, and is seen in stout people. It usually follows the ingestion of a heavy meal. The attack of pain is dramatic, sudden, and excruciating. It is felt in the epigastrium and radiates into one or both loins. In this way pancreatic pain radiation resembles an inverted fan. It is relieved when the patient sits up or lies on his abdomen, and is aggravated when he is on his back. Therefore, in most pancreatic conditions, be they tumors or inflammations, the patient is usually found sitting, elevated, or on his abdomen. Reflex vomiting or retching almost always occur; emesis which is truly reflex in nature is never feculent.

Physical examination reveals a patient that is usually in shock with cold and clammy extremities, sub-normal temperature, and a rapid, thready pulse. Local epigastric tenderness is almost always present and is associated with a type of muscular defense which is localized to the same area. The rigidity is not truly board-like in nature, and the tenderness is most marked midway between the umbilicus and the xiphoid. An occasional finding is ecchymosis in one or both loins, or at times around the umbilicus. This is due to extravasated blood which finds its way around the retroperitoneal space and presents itself as greenish yellow or purplish discolorations. This finding, however, takes two or three days to appear. Mild jaundice is found in about half the cases; this is explained by the fact that the common duct is pressed upon by a

swollen head of the pancreas. Abdominal auscultation usually reveals a quiet but not silent abdomen.

Laboratory findings which aid are an increase in blood or urinary diastase and a glycosuria. Polowe has emphasized the importance of determining the blood amylase activity in terms of cuprous oxide precipitation. He has shown that moderate to marked blood amylase activity is almost always associated with diseases of the pancreas, and normal or decreased blood amylase almost always excludes pancreatitis. A flat x-ray plate of the abdomen may reveal a separation of the upper and lower limbs of the duodenum brought about by an edema of the head of the pancreas. This latter finding is unusual.

Renal Colics: Stones are not the only substances which produce renal colics, since the same syndrome may be produced by a small blood clot, inspissated pus, uratic debris, or a kinking of the uretero-pelvic junction in a ptotic kidney.

The condition is most frequently seen in males, and the patient may reveal a history of previous attacks, a hereditary influence, a story of gout, or parathyroid pathology.

The patient complains of a sudden pain which starts in the lumbar region and radiates to a corresponding testicle or vulva. With this pain he becomes extremely restless and thrashes about. It is important to recall that a patient who is experiencing a colic is restless and moves, but one who has a peritonitis lies perfectly quiet and resents being moved. Vomiting is a common symptom, as is a frequency of urination. During the act of micturition the colicky pain may be altered.

Physical examination rarely reveals any elevation in temperature, but extremely characteristic of the condition is a bradycardia. It has ofttimes been stated that when a patient with an acute abdomen has "a clean tongue and a slow pulse" he has a renal colic until proved otherwise. Tenderness is most marked in the region of the twelfth rib on the involved side, and to elicit this finding it is unnecessary and cruel to utilize any type of "punch" test. The tenderness is so exquisite that mild percussion will demonstrate it. We prefer to use the term "Murphy tap" to "Murphy punch." A zone of hyperesthesia is usually found posteriorly at the level of and slightly below the twelfth rib. If this area is anesthetized with novocaine, the hyperesthesia and pain disappear.

A flat x-ray plate may reveal a stone if such is present, but this is not reliable since non-opaque substances produce kidney colic. A catheterized specimen of urine usually reveals pus, blood, and albumin. The presence or absence of pus and blood in the urine is not pathognomonic since a stone may completely block the ureter and result in a normal urine. On the other hand, an inflamed appendix may be attached to the ureter, kidney, or bladder, resulting in a secondary ureteritis, nephritis, or cystitis with an associated hematuria. In such instances the laboratory report may be actually misleading.

Coronary Occlusion: Although this belongs to the realm of the internist, the general practitioner as well as the surgeon must be on his guard to avoid the fatal error of confusing an acute coronary disease with an acute abdominal condition.

Men are more susceptible to this condition, and it is usually found in those past the age of forty. A previous history of dyspnea or pain in the chest during exertion or excitement may be elicited. The attack is sudden, with severe pain in the chest which radiates out the left arm, towards the abdomen or both shoulders. There is a sense of impending death with severe fright which usually supersedes the complaint of pain. The radiation may also be towards the epigastrium, so that the examiner's attention is directed to the abdomen rather than the chest. A usual complaint during such an attack is one of "indigestion." Although the pain of acute coronary disease may occur in the abdomen, it does not become localized; hence, no area of local abdominal tenderness is ever found. Marked abdominal distention may be present in coronary pathology, but muscle defense or rectus rigidity are lacking. In abdominal catastrophes the patient lies perfectly quiet, but the coronary patient resembles the colic in that he is restless and tosses about. The acute cardiac patient presents veins in the neck which are distended and full, in contrast to the patient with the surgical abdomen that may appear pale and bloodless. Signs of impaired circulation are revealed by the coronary, such as dyspnea, orthopnea, and cyanosis. Auscultation will usually reveal rales in both bases due to pulmonary congestion. Cardiac enlargement, feeble heart sounds, and occasionally a pericardial friction rub may be found. During auscultation of the abdomen, normal intestinal sounds will be heard which are absent or diminished in cases of peritonitis.

Positive electrocardiographic findings are pathognomonic, but one is not always fortunate enough to have an electrocardiogram handy. A leukocytosis may be present some hours after the disease takes place, and the urine is usually negative unless there is associated renal pathology.

1947 DUES ARE PAYABLE JANUARY FIRST.

PENICILLIN IN THE TREATMENT OF SUBACUTE BACTERIAL ENDOCARDITIS

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INDIANAPOLIS

This report deals with the use of penicillin in the treatment of nine cases of subacute bacterial endocarditis at the Methodist Hospital during 1944 and 1945. Six of the nine cases have been clinically free of active infection from six to twenty-one months after treatment was discontinued. The remaining three cases have died. The diagnosis in all the cases was made upon the presence of a continuous fever, evidence of valvular heart disease, evidence of embolic manifestations, and more than one positive blood culture. This paper includes a discussion of several clinical and therapeutic aspects of this disease.

PREDISPOSING CAUSES

In one case multiple dental extraction was followed immediately by symptoms of subacute bacterial endocarditis. Another case had no definite exciting factor, but developed a large tooth abscess thirty-one weeks after treatment was started. The pus from this abscess showed on culture the same organism that was found in the blood cultures on many occasions previous to the development of the abscess. Three other cases had multiple dental extractions approximately three to four months prior to the onset of subjective symptoms. In these latter cases it is questionable whether the dental work was the exciting factor. One case followed a septic abortion. In three cases no predisposing factor could be determined. It is evident that dental procedure precedes the onset of this disease in a relatively large number of cases.

Budnitz and others[1] stated that Kelson of the Massachusetts General Hospital found a 10 per cent incidence of recent dental surgery in 250 cases of subacute bacterial endocarditis, and later a 25 per cent incidence in 500 cases. Kelson and White[2] found that upper respiratory infections and grippe were the most frequent precursors, with dental procedure, particularly extraction, next in frequency. On the other hand, Schwartz and Salman[3] found no instance of subacute bacterial endocarditis following a total of 403 extractions among 98 patients with advanced rheumatic heart disease. It is interesting that Okell and Elliott[4] found that single or multiple extraction led to a streptococcus bacteremia in 34 per cent of cases in which no gingival disease was apparent and in which a general anesthetic was used. They also pointed out that only 17 per cent had a postextraction bacteremia when local anesthetics were used. Pressman and Bender[5] found that bacteremia may even occur after the act of chewing.

PRIMARY CARDIAC DISEASE

Three of the nine cases in this series were aware of having rheumatic heart disease. Three others gave a definite history of having had rheumatic fever symptoms during childhood. The remaining three cases were not aware of having had preexisting heart disease, although this does not exclude the probability that they had previous valvular heart disease. Five of the nine cases had a mitral insufficiency. Three cases had aortic insufficiency, and only one case had an advanced mitral stenosis.

DURATION OF INFECTION

In this series no correlation exists between the duration of the disease and the outcome of the treatment. It is noted, however, that those cases that had the longest duration of infection had a considerably higher incidence of complications, such as serious embolic phenomena, congestive heart failure, and one case of ruptured aneurysm. In the series of Dawson and Hunter[6] no direct relationship between duration and outcome of treatment existed. Also White and others[7] only partially confirmed the fact that the milder the infection and the earlier the treatment, the better the prognosis.

CAUSATIVE ORGANISM

Two cases had a non-hemolytic streptococcus, and the other seven had streptococcus viridans. No definite correlation between infecting organism and response to treatment was observed.

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[1] Budnitz, E.; Nigel, A.; and Berg, L.: Prophylactic Use of Sulfapyridine in Patients Susceptible to Subacute Bacterial Endocarditis following Dental Surgical Procedures, *J. Am. Dent. Assoc.* **19**:346, 1942.

[2] Kelson, S. R., and White, P. D.: Notes on Two Hundred and Fifty Cases of Subacute Bacterial (Streptococal) Endocarditis Studied and Treated between 1927 and 1939, *Ann. Int. Med.* **22**:40, 1945.

[3] Schwartz, S. P., and Salman, I.: The Effects of Oral Surgery on the Course of Patients with Disease of the Heart, *Am. J. Orthodontics* (Oral Surg. Sect.) **28**:331, 1942.

[4] Okell, C. C., and Elliott, S. D.: Bacteriemia and Oral Sepsis, with Special Reference to the Aetiology of Subacute Endocarditis, *Lancet.* **2**:869, 1935.

[5] Pressman, R. S., and Bender, I. B.: Effect of Sulfonamide Compounds on Transient Bacteremia following Extraction of Teeth: Sulfanilamide, *Arch. Int. Med.* **74**:346, 1944.

[6] Dawson, M. H., and Hunter, T. H.: The Treatment of Subacute Bacterial Endocarditis with Penicillin, *J.A.M.A.* **127**:129, 1945.

[7] White, P. D.; Mathews, M. W.; and Evans, E.: Notes on the Treatment of Subacute Bacterial Endocarditis Encountered in Eighty-eight Cases at the Massachusetts General Hospital During the Six-Year Period 1939 to 1944 (Inclusive), *Ann. Int. Med.* **22**:61, 1945.

SENSITIVITY OF THE INFECTING ORGANISM

Unfortunately in this series only a few cases had determinations of the penicillin sensitivity of the infecting organism. These studies and penicillin blood levels should be performed as a guide to determine dosage requirements. This is especially indicated in the cases that have relapsed or are not responding well to the treatment used. Favour and others[8] believe that a good rule is to maintain a blood level five or more times the minimal effective level.

There has been considerable discussion concerning the possibility of the infecting organism becoming penicillin-resistant, especially in cases with several relapses. Flippen[9] found that in cases that relapsed the infecting organism showed a definite loss of sensitivity to penicillin. Dawson and Hunter[10] in their second report, however, have found no cases in which the infecting organism developed significant resistance to penicillin. In this series also there was no evidence that the infecting organism became markedly resistant to penicillin even though several patients received penicillin continuously for many months.

ANTICOAGULANT DRUGS

Three cases received anticoagulant drugs. The patient who has been symptom free for twenty-one months received heparin one week and dicoumarol two weeks in addition to penicillin. The most difficult case to control received heparin two weeks and dicoumarol three weeks, and had several relapses afterwards. This patient later responded to penicillin alone. Another case died of a cerebral vascular episode after being on dicoumarol. An autopsy was not performed, and it was not possible to determine whether this was a cerebral vascular hemorrhage or a cerebral embolism originating in the vegetations of the heart. From this series it is concluded that anticoagulants are dangerous, difficult to control, and are not necessary in the effective treatment of subacute bacterial endocarditis.

DOSAGE OF PENICILLIN

In this series the dosage of penicillin and the length of treatment varied greatly because at the time several of these cases were being treated the supply of penicillin was limited.

The daily dosage varied from 60,000 to 1,000,000 units. The total dosage varied from 2,500,000 to 48,000,000 units.

Two cases recovered after relatively small total dosages of penicillin. One case received only 2,500,000 units, and the other only 5,400,000. In all other instances, however, where the daily dosage was 200,000 units or less, the infection either continued or recurred after therapy was discontinued. On the other hand, there was only one recurrence in the cases which received a daily dosage of 500,000 units or more for a period of at least three weeks. The one exception was a case of aortic insufficiency. This case received 400,000 units daily for one week, followed by 800,000 units daily for three more weeks. This case later relapsed and died of congestive heart failure, with evidence of active infection. It was also noted that the other case of aortic insufficiency was very difficult to control. It is concluded that the cases with aortic insufficiency require considerably larger doses of penicillin than those with only mitral involvement. Favour and others[8] also state that a million units daily were required in their cases of aortic insufficiency.

From the experiences in these cases one would conclude that the minimum daily dosage should be 500,000 units for at least five weeks of treatment. Each case is an individual problem, and many cases, especially those with a highly-resistant organism, aortic insufficiency, or numerous relapses may require larger doses and perhaps even a longer period of treatment. Dawson and Hunter[10] believe, however, that the period of treatment need only be of two or three weeks' duration if the penicillin blood level is at least four times the sensitivity level, using a continuous intramuscular method of administration.

METHOD OF ADMINISTRATION OF PENICILLIN

In these cases penicillin was given by intramuscular injections, continuous intravenous, and continuous intramuscular methods. The disadvantages with the continuous intravenous and continuous intramuscular routes were that regulation of flow was difficult, several intramuscular abscesses occurred, the flow often stopped for three or four hours during the night, and constant nursing care was needed. The most satisfactory route in this series was the two-hour intramuscular injections. If this method caused considerable discomfort a continuous intramuscular route was alternated. It was interesting that several of these cases were sent home to receive their penicillin by various members of the family, thus reducing hospital expenses. It was also noted that those patients who were permitted bathroom privileges and an hour or so in a chair daily during treatment had a remarkable sense of well-being, and no complications were sustained in any of these cases.

COMPLICATIONS

The common complications of this disease were found in this series. The most important one was congestive heart failure. There were also two cases of cerebral embolism, one case of repeated splenic infarction, one case of renal infarction, one case of either a cerebral hemorrhage or cerebral embolism which died, and one case of rupture of an

[8] Favour, C. B.; Janeway, C. A.; Gibson, J. G., II; and Levine, S. A.: Progress in the Treatment of Subacute Bacterial Endocarditis, *New Eng. J. Med.* **234**:71, 1946.

[9] Flippen, H. F.; Maycock, R. L.; Murphy, F. D.; and Wolferth, C. C.: Penicillin in Subacute Bacterial Endocarditis, *J.A.M.A.* **129**:841, 1945.

[10] Dawson, M. H., and Hunter, T. H.: The Treatment of Subacute Bacterial Endocarditis with Penicillin: Second Report, *Ann. Int. Med.* **24**:170, 1946.

SUMMARY OF NINE CASES OF SUBACUTE BACTERIAL ENDOCARDITIS TREATED WITH PENICILLIN

No.	Age	Sex	Primary Cardiac Disease	Probable Exciting Factor	Probable Duration of Infection	Organism	Dose in Units and Route	No. of Days	Total Dosage	Result	Comment	Follow-up, Months
1	58	M.	Rheumatic (mitral)	Multiple Tooth Extraction	2	Strept. viridans	120,000 IM injections	21	2,500,000	Recovered	Well	21
2	29	F.	Rheumatic (mitral)	Criminal Abortion	4	Strept. viridans	60,000-120,000 IM injections	35	2,500,000	Died	Case received dicoumarol. Died of cerebral vascular episode. No autopsy.	
3	55	M.	Rheumatic (aortic)	Tooth Abscess?	2	Non-hem. strept.	(a) 100,000 IV	14	1,400,000	Infection	Aortic insufficiency not present at onset became markedly advanced during the infection. Tooth abscess developed after thirty-one weeks of treatment showed pure culture non-hem. strept. Patient after treatment had symptoms of congestive failure at rest.	7
							(b) 80,000 IM injections	7	560,000	Existed		
							(c) 160,000 IM injections	133	20,160,000	Infection existed		
							(d) 100,000 IV 90,000 IM injections	44	9,310,000	Infection existed		
							(e) 500,000 cont. IM drip	21	10,500,000	Recovered		
							(f) 240,000 IM injections	27	6,480,000	Recovered		
								246	48,410,000			
4	61	M.	Rheumatic (mitral)	None	2	Non-hem. strept.	(a) 120,000 IM injections	63	7,560,000	Recovered	Well	10
							(b) 200,000 to 300,000 IM injections	126	31,440,000			
							(c) 1,000,000 IM cont. drip	7	7,000,000			
								196	46,000,000			
5	39	F.	Rheumatic (mitral)	Multiple Tooth Extraction? (4 mos. prior to onset)	5	Strept. viridans	(a) 160,000 IM injections	26(a)	4,160,000	Relapsed	Well	6
							(b) 160,000 IM injections	12(b)	2,000,000	Relapsed		
							(c) 160,000 IM injections	12(c)	2,000,000	Relapsed		
							(d) 160,000 IM injections	12(d)	2,000,000	Relapsed		
							(e) 300,000 cont. IM drip	5(e)	1,500,000	Infection absent		
							(f) 500,000 cont. IM drip	24(f)	12,000,000	Infection absent		
							(g) 400,000 IM injections	60(g)	24,000,000	Recovered		
								151	47,660,000			
6	52	F.	Rheumatic (mitral)	Tooth Extraction?	3	strept. viridans	(a) 300,000 IM cont. drip	4	1,200,000	Recovered	Well	10
							(b) 600,000 IM injections	26	15,600,000			
								30	16,800,000			
7	36	M.	Rheumatic with possible luetic involvement (aortic)	Tooth Extraction?	2	Strept. viridans	(a) 400,000 IM injections	8	3,200,000	Infection existed	This case had a marked aortic insufficiency and he died of congestive failure. Evidence of infection present at time of death.	
							(b) 800,000 IM injections	21	16,800,000	Infection absent		
							(c) 320,000 IM injections	10	3,200,000	Relapsed—Died		
								39	23,200,000			
8	42	M.	Rheumatic (mitral)	None	1	Strept. viridans	200,000 IM injections	27	5,400,000	Recovered	Well	8
9	29	M.	Rheumatic (aortic)	None	3	strept. viridans	210,000 IM injections	1	210,000	Died	Died within twenty-four hours after therapy started. Autopsy revealed a ruptured aneurysm in wall of left ventricle with a hemopericardium.	

aneurysm of the left ventricle. With the advent of penicillin the prognosis in subacute bacterial endocarditis is largely dependent upon the complications that occur. Bloomfield and Halpern[11] believe that the high incidence of cardiac complications in their series may be accounted for by the deformities and destruction of valves which seem to go hand in hand with the absorption of vegetations under penicillin therapy.

DENTAL PROCEDURES

The majority of these cases had dental consultation including complete x-rays. If extractions were indicated, they were done during the period of treatment. One unusual case developed a tooth abscess two and one-half months after therapy was discontinued. Penicillin was started again, and the abscess was drained and the tooth later removed. This abscess appeared thirty-eight weeks after the onset of his illness, and culture of it revealed it loaded with non-hemolytic streptococcus, which was the original infecting organism. The patient has been free of symptoms of active infection for seven months following the tooth extraction. It is believed that all cases of rheumatic heart disease and cases of subacute bacterial endocarditis should be on adequate doses of penicillin when dental extractions are performed.

POST-THERAPY FOLLOW-UP PERIOD

According to the experience of Dawson and Hunter,[6, 10] the prognosis is excellent in the cases which remain clinically and bacteriologically free from infection for one month after therapy has been discontinued. In their second report they found no case which relapsed after two weeks. There were many relapses in the cases in this series; however, all of them occurred within three weeks after therapy was discontinued. The post-therapy follow-up period in this series varied from six months to twenty-one months.

SUMMARY

Nine cases of subacute bacterial endocarditis were treated with penicillin. The infecting organism was streptococcus viridans in seven cases, and non-hemolytic streptococcus in two cases. One case died of a ruptured ventricular aneurysm within twenty-four hours after treatment was started, and therefore should not be included as a failure in penicillin therapy. Two other cases have died, one of a cerebral vascular accident while on therapy and the other with a combination of aortic insufficiency, congestive heart failure, and active infection. Six of the nine cases are clinically free of active infection from six to twenty-one months after treatment was discontinued. These six cases are in good general health except for one who has a marked aortic insufficiency and congestive heart failure.

Some general conclusions that can be reached from observations made in this series are that dental procedure preceded the onset of the disease in a relatively large number of cases. All cases of rheumatic heart disease and subacute bacterial endocarditis should receive adequate dosage of penicillin during dental extractions.

In these cases the preferred method of administration was the two-hour intramuscular injection. No correlation existed between the infecting organism and the outcome of treatment. It was thought that anticoagulants were not necessary in the effective treatment of this disease. There was no evidence of remarkable resistance of the infecting organism to penicillin. There were many relapses but all occurred within three weeks after treatment was discontinued. Studies concerning penicillin sensitivity and penicillin blood levels should be done in all cases as a guide to dosage requirements.

It seems that a minimum daily dosage should be 500,000 units and the period of treatment at least five weeks. Large doses of a million or more units daily will be required in some cases, especially those with aortic insufficiency, a highly resistant organism, or numerous relapses.

It is concluded that penicillin is an effective agent against subacute bacterial endocarditis, nevertheless, frequent cardiac complications are still a major problem. Perhaps early diagnosis of this disease and intelligent treatment will help lower the incidence of cardiac complications.

[11] Bloomfield, A. L., and Halpern, R. M.: Penicillin in Subacute Bacterial Endocarditis, *J.A.M.A.* **129**:1135, 1945.

CANCER CONTROL IS A MAJOR HEALTH PROBLEM

Cancer control is a major health problem in the United States. As such, it merits attention not only in programs of research, but also in programs of education. Instruction concerning the nature of cancer and known methods of prevention and control should be included in the high school course of study, along with other important health problems facing the American people today. High school students are interested in such information. Scientific facts should be taught to them so that fears may be allayed, intelligent action as future adults be promoted, and families favorably influenced by the information which students relay to adult relatives.

POSTOPERATIVE ABDOMINAL ADHESIONS AND COMMON ERRORS CAUSING THEM

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One of the problems most frequently met by the abdominal surgeon is that of adhesions with resulting symptomatic partial bowel obstruction. Every operator of experience has been confronted time and again with this condition, and the suggestions for prevention of recurrence of intestinal adhesions are almost as numerous as the patients who have them. As in the treatment of burns, the multiplicity of suggestions offered bears ample evidence that there is as yet no single solution to the problem. Boys has written an extensive paper on this subject.[1]

In the light of the present ever-increasing number of abdominal operations and the many patients coming back to surgery for the relief of peritoneal adhesions, it behooves the surgeon to familiarize himself with the pathology, the common causes of adhesions in the abdomen, and possible means of preventing them. Treatment of adhesions has been adequately described by Noble,[2] but the subject of causation has been neglected.

Unfortunately with the advent of the sulfonamides, penicillin, et cetera, a great many men have lost their fear of peritonitis, be it local or diffuse, and accordingly fail to reckon with the terminal picture which will ultimately present itself whether the cause of the initial insult be bacterial, chemical, or directly traumatic. The fact that the patient recovers from his initial condition does not mean that certain unalterable pathological changes have not been set in motion and that eventually the patient will not again become a candidate for surgery.

It is not the purpose of this paper to discuss at length the various stages and types of peritonitis, but rather to point out the mistakes so often made in abdominal surgery which eventually lead to further operative procedures. It is not at all uncommon to see a patient who has had three or four abdominal operations, the first for appendicitis, salpingitis, fibroids, et cetera, and the remainder for adhesions. In a recent series of fifty cases re-operated by the author there were only two in which some type of intra-abdominal adhesion was not present.

With such a series in mind it becomes apparent at once that somewhere along the line our surgical procedures are at fault, for certainly that many patients did not suffer from diffuse suppurative peritonitis. In the cases where such massive pathology has been present we naturally expect to find residual difficulty, but it is the so-called "clean case" in which we are primarily interested.

All too frequently a patient comes to the office with the history of having had an extensive abdominal operation, usually pelvic, and of having been "fine" for a few weeks or months, and then developing a feeling of vague abdominal discomfort with mild constipation. At first these patients seem to find relief in mild catharsis or enemas, but the discomfort gradually increases, with bloating and cramping pains, and eventually a picture of actual malnutrition develops because the patient finds that food intake aggravates the abdominal pain. At this stage the patient comes in seeking relief.

Careful history and examination (and occasionally x-ray studies) rarely fail to disclose anything save intestinal dysfunction due to twisted and snarled loops of gut. Surgery for the relief of adhesions is advised.

At this point it is well to consider pathology and causative factors leading to the necessity for re-operation in these cases. The pathology is, of course, obvious. A serofibrinous exudate has formed as the result of visceral peritoneal insult, and a sticky peritonitis with resulting gluing together of the bowel follows. The many causes of peritonitis need no review, but the peritoneal insult instigated by the surgeon needs critical survey.

The first and foremost requisite of all good surgery is kindness to tissue. Violent handling, pinching, and roughing of the gut is perhaps the most common error of abdominal surgery. The abdomen is often slashed open in dramatic fashion and the intestines pushed about roughly as the surgeon explores the cavity. This stage all too often finds the surgeon wearing an unwashed glove to which cling innumerable particles of talcum powder. Talcum in itself is abrasive enough to cause localized areas of peritonitis, and later adhesions. Accordingly, the surgeon should never under any circumstances place a gloved hand in the abdomen which has not first been carefully washed of all abrasive material.

The second and perhaps gravest of all errors in abdominal surgery is the installation of the hot gauze pack. Huge wads of hot, wet gauze are stuffed into the belly and the intestines are carefully packed off to give adequate exposure and operating room. In addition to the direct abrasive trauma of these cumbersome packs there is thermal injury. Rare, indeed, is the surgery equipped to determine the actual temperature of the "hot"

[1] Boys, F.: Prophylaxis of Peritoneal Adhesions, *Surgery*, **11**:118, 1942.

[2] Noble, T. B., Jr.: *The Treatment of Peritonitis and its Aftermath*, A. Vernon Grindle, Indianapolis, 1945.

gauze being placed in the abdomen, and more often than not the solution from which it is wrung is far too hot for safe application.

In many parts of the country the steep Trendelenburg position is still used, and with the abdomen full of gauze, the intestines in an abnormal position, and the respiratory excursion increased, the rasping to-and-fro motion is equivalent to the use of an emery cloth on the visceral peritoneum. We have then insulted the peritoneum with heat, placed an abrasive substance in direct contact, and aggravated it by active motion. Naturally, following an hour, or often longer, of such treatment, traumatic peritonitis with all of its vicious aftermath follows.

Further, we find many men still insisting on the use of packs or towels along the wound edges, peritoneal clamps, and self-retaining retractors. Each and every one of these is an invitation to disaster and to adhesions along the line of closure of the wound. No tissue can withstand the continuous pressure of a large self-retaining retractor for any time, however minimal, without some pressure necrosis. Again we are adding insult to injury.

More often than not we hear admonition to adequate exposure, which usually means lengthy incisions that unnecessarily expose the gut to dehydration and consequently low grade peritonitis as a result of the drying-out process. No surgeon will deny the need for operating room, but careful study and examination will often eliminate the need for large incisions. The incision need be only long enough to permit removal of pathological tissue, tumors, et cetera, and thus we do away with the need for massive gauze packs and retractors that serve to insult the visceral peritoneum.

Again, one of the most common causes of surgeon-instigated peritonitis is the practice of inversion of the stump following appendectomy.

Sutures in the gut, whatever the material used, set up suture peritonitis, and with the resultant outpouring of plastic exudate comes adhesions of adjacent loops of gut. Simple ligation of the appendix with carbolization of the stump and wiping away of excess acid to limit its action locally, not inversion, is the procedure of choice. Nothing distal to a ligature will stick in the abdomen, and thus we need have no fear of dropping back the simply-ligated stump.

This method of handling Meckel's diverticulum is also advisable, and any complicated procedure is bound to bring on suture peritonitis, as is also true in the case of anastomosis, and the use of too much suture material often does far more harm than good.

Further, we mention, only to condemn, the practice still used in many places of putting foreign materials in the abdominal cavity with the intent to prevent adhesions. In this case we need only mention a few, such as liquid petrolatum, glucose, amniotic fluid, fats, ether, et cetera, all of which have failed utterly to prevent the terminal picture of multiple adhesions. There is no sound physiological reason for the instillation of these or of any other material into the abdominal cavity.

Finally, early active motion and early rising are very important factors in the prevention of adhesions, and with proper wound closure we need have little fear of postoperative herniation.

SUMMARY

The need for more thorough understanding of the underlying causes of postoperative adhesions is presented along with an enumeration of some of the common errors in surgical technique which lead to their formation and to further surgery. Common errors are:

(1) Use of gloves from which abrasive talcum powder has not been washed.

(2) Use of hot, moist packs in the abdomen along with the steep Trendelenburg position.

(3) Use of skin-edge towels along with various types of clamps and self-retaining retractors.

(4) Failure to recognize suture material as a cause of local peritonitis.

(5) Placing of foreign materials, such as glucose, amniotic fluid, et cetera, in the abdomen.

(6) Keeping patients in bed too long following surgery.

ALLERGY DRUG PRESENTS SERIOUS INDUSTRIAL HAZARD—DROWSINESS

Two Rochester, New York, physicians warn that benadryl, a very effective drug for allergic skin diseases, is dangerous to persons operating any kind of machine, especially an automobile, because it may produce drowsiness, according to an article in the September 28 issue of *The Journal of the American Medical Association.*

Benjamin J. Slater, Associate Medical Director, Eastman Kodak Co., and Nathan Francis, of the Medical Department of the Eastman Kodak Co., in Rochester, state that "because of this narcotic side reaction incident to the taking of benadryl, the drug may be a serious hazard when used by persons operating automobiles or in industry operating moving equipment or machinery."

In their series of sixty-five cases, the authors point out that drowsiness was a common symptom in twenty-five. "This figure should be increased somewhat," they say, "as many of our patients were instructed to take the drug only at bedtime. Invariably they reported that they slept better than usual. Drowsiness may occur from one to three hours after taking benadryl, and this drowsiness may be cumulative if the drug is continued."

A case report of one of their patients serves to illustrate how dangerous the effect of the drug may prove. A twenty-year-old man was given a 50 milligram capsule of this drug to relieve severe symptoms of hay fever. The second day of treatment he took the capsule just before going to work. He complained of feeling drowsy. An hour later, while driving an electric platform cargo truck, he lost control of the truck and it fell off the platform. Fortunately, he jumped in time to avoid injury.

THE LIMITATIONS OF CHEST X-RAY INTERPRETATIONS*

BRUCE W. STOCKING, M.D.†

MUNCIE

At the present time the most efficient and valuable instrument we possess for finding and managing cases of active pulmonary tuberculosis is the x-ray examination of the chest. Nowadays such a statement causes no surprise and rarely any argument. This was not always so: years of argument and exposition were required to convince some doubters and die-hards that the time-tried methods of diagnosis, consisting of thumping the chest, listening to it with the stethoscope, and analyzing its secretions could be assisted by the use of x-ray examination. It has seemed to me in recent years, however, that we are in danger of taking much too extreme an attitude in favor of the use of x-ray survey methods, to the detriment particularly of the efficient utilization of information in our case-finding programs; that we are inclined to believe too much in x-ray examination alone and unaided, and that we are dangerously inclined to forget its limitations. We are also apt to disregard the weaknesses of the various x-ray survey procedures which have come into widespread use, particularly as to the exact evaluation of reports based upon them. The object of this presentation is to consider the limitations of the methods now in common use.

The end result of any x-ray examination is a medical opinion. It happens that the radiologist arrives at his opinion by looking at x-ray films and analyzing the shadows thereon rather than by the methods used by other specialists, such as the bronchoscopist who arrives at his opinion by looking down the trachea through a long tube, or the urologist who looks into the bladder with a special instrument. The value of the opinion rendered in any medical consultation depends directly and most importantly upon the knowledge and skill of the man who gives the opinion, and this depends upon training and experience. This skill is one of the limiting factors of the value of the procedure. Another important factor is the technical nature of the materials to which that knowledge and skill is applied. There is an old proverb among radiologists which reads like this: "A poor film is worse than no film at all, and the best film is only as good as the man who reads it."

Assuming that the person who is to deliver these opinions is adequately trained, a state of grace attained not only by radiologists but also by some specialists in the treatment of diseases of the chest, what technical procedures are available to him today? I shall list them in what I consider to be the order of the accuracy with which they may be interpreted:

1. Stereoscopic standard x-ray films, 14 x 17 inches.
2. Single standard x-ray films, 14 x 17 inches.

Survey Methods

3. Stereoscopic photofluorograms, 4 x 5 inches.
4. Single photofluorograms, 4 x 5 inches.
5. Paper x-ray films, 14 x 17 inches.
6. Seventy millimeter photofluorograms.
7. Thirty-five millimeter photofluorograms.
8. Fluoroscopy.

The 14 x 17 inch x-ray film has been the basis of the standard examination of the chest for years, and with its use the examination attained its present position of high regard. It was discovered by a series of capable workers that by this method evidence of pulmonary tuberculosis could be detected much earlier in the course of the disease than by any other technique; that the extent of the disease could be described with a greater degree of accuracy than by any other method; and that significant information regarding the activity or inactivity of the infection could be found. It was also brought out as experience accumulated that other diseases could produce an appearance in the x-ray film very closely approximating, sometimes almost perfectly simulating, the appearance produced by pulmonary tuberculosis, and that careful clinical study of the case using all other available methods was necessary before a reliable and reasonably certain diagnosis could be arrived at. These confusing disease entities include atypical or virus pneumonia, unresolved pneumonia, certain types of chronic, non-specific pneumonitis, silicosis, varicosities of the bronchial or pulmonary veins, lung abscess, lymphoblastoma, bronchogenic carcinoma, Boeck's sarcoid, and others. It was found that in many cases it was necessary to secure so-called "serial" examinations, that is, repeated examinations separated by periods of time, and utilize the change or lack of change shown therein as a further source of information in addition to the clinical history of the case, the physical examination, the differential blood count, urinalysis, sedimentation rate, sputum examination, examination of gastric washings, et cetera, before any reliable opinion could be given. At the end of the report of a radiologist one almost never sees the word "diagnosis"; the words in most common use are "impression" or "opinion," which indicate the point of certainty beyond which a radiologist is seldom justified in going. It was, of course, pointed out from the earliest use of x-ray that all clothing which might produce any foreign or adventitious

* Presented before the Thirty-fifth Annual Meeting and Conference of the Indiana Tuberculosis Association, at Indianapolis, on May 9, 1946.

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shadows must be removed lest the radiologist be deceived into a false impression.

Despite the limitations which I have purposely emphasized, the efficiency with which x-ray can point the way to early diagnosis and assist in the selection and evaluation of treatment procedures has led to its widespread use, and properly so. It has also led to a strong desire on the part of all sorts of persons engaged in the fight against tuberculosis to subject the whole population to x-ray examination in order to discover those infected with tuberculosis, treat or isolate these individuals, and thus eradicate the disease. For this purpose the regular type of examination for surveys in numbers was expensive in materials, labor, and file space, and the search for cheaper or more convenient methods began. Cheaper methods have been discovered, but with a proportionate loss of accuracy, for no cheap method has yet been devised whose dependability can duplicate that achieved with the use of the 14 x 17 film. In the list of methods given above I have indicated my own idea of the sequence in which efficiency decreases, based to some extent on the literature, to some extent on personal communications from colleagues, and to some extent on personal experience. I believe that any physician with experience with these methods will admit that there is a definite loss of accuracy with the methods listed as Nos. 3 to 8, as compared with standard technique, even though he may not agree with the order in which I have placed them. It must be emphasized that if accuracy within the limits of the size of the image recorded on the film is to be maintained, there can be *no* cheapening of the mechanical equipment, for if one wishes, for convenience, to reduce the size of the image to a 35 millimeter or 70 millimeter film, there must be introduced into the mechanical process fine lenses, cameras, and fluoroscopic screens, high-intensity x-ray generators and fine-focus x-ray tubes, preferably with rotating anodes. Although convenience and cheapness of films may be served in the miniature, unless the survey unit is equipped with unusually excellent apparatus the result of the survey will be vitiated before the films come to the radiologist or phthisiologist for interpretation. These survey methods have a proper place if the people using them will not forget the limitations of the several procedures and will not exceed proper limitations in the use of the information derived.

All the survey techniques listed are merely screening methods having only the virtue of using less expensive materials, or of having the convenience of mobility of apparatus. In individual cases some details can be made out, but I do not think that it is prudent even for an expert to try to report these details; the only purpose the survey methods serve is to detect those individuals who should have further investigation. None of the survey methods constitute adequate x-ray examination of the chest.

Once this "survey concept" is accepted, the selection of methods for various types of surveys is not too difficult, it seems to me. Where small numbers of people are to be examined I think that the single 4 x 5 is preferable. I see no practical advantage for the stereoscopic 4 x 5 in survey work. Where large numbers of people are to be examined at one time, as in a community, school, or factory survey, my choice would be the 70 millimeter roll film. I place fluoroscopy last on the list because it has less to recommend it than any of the others. It is the least accurate, even in experienced hands, and in inexperienced hands it is almost useless, not to say dangerous; it leaves no record; it exposes the examiner to the possibility of receiving overdoses of radiation; and it requires the most of the most-expensive item in any survey project—the time of the skilled examiner.

In connection with the reporting of survey examinations I would like to say a word about "calcification." Early investigators found out many years ago that the first, or "childhood" infection, tends to heal with the deposition of calcium salts in the lung scar; that later infections sometimes do occur; and that these calcifications cast shadows on the x-ray film. It has been assumed in the past, and quite erroneously, that all calcifications whose shadows are seen on x-ray films are due to tuberculosis, but other infections, notably histoplasmosis (Carroll E. Palmer) may leave calcareous scars, and probably are quite benign. Even if the calcifications are the result of tuberculous infection they represent locally a healed phase of the disease, and such individuals may have, if anything, greater resistance than others to reinfection and active adult pulmonary tuberculosis. In view of these circumstances it seems to me inadvisable to report the presence of these calcifications to the individuals concerned, except perhaps as evidence of previous infection, not active tuberculosis, and it is possible that the difference between the two situations may be too subtle for the layman to grasp. It seems to me that it is better to let him carry his calcifications unconsciously rather than terrify him with the specter of tuberculosis. It must also be taken into consideration that the diagnosis of calcification from certain types of survey films is inevitably inaccurate, partly due to the distortion of the blood vessel markings in the inner lung zones, due to the short distances employed, which makes some perfectly innocent blood vessels look like calcifications, and partly due to the common custom of taking these films through the individuals' ordinary clothing. Most of the foreign shadows are obvious, such as zippers, campaign buttons, buckles, clips, and the numerous safety pins which seem inevitable in present-day clothing, but there are some substances in clothing which, although not interfering with the fundamental usefulness of the survey procedure, do interfere with any attempt to make a meticulous, exact survey of the presence or absence of calcification. Certainly a report of the presence of calcification

based on a survey film is no reliable indication for calling a person in for re-examination.

The examination with 14 x 17 films, being the most dependable, should invariably be done on any patient suspected of having a lesion before he is informed by his physician that he has pulmonary tuberculosis. Only films of this size can be a proper basis of a radiologist's or phthisiologist's report to the patient's physician that this patient probably, almost certainly, has pulmonary tuberculosis; in the common phrase of the report, "Impression: Pulmonary Tuberculosis." The physician must then analyze the history, physical findings, and laboratory findings in relation to the x-ray evidence and inform and advise his patient accordingly.

In my opinion there is no excuse for a definite diagnosis based on less information than I have outlined, nor is there any excuse for the physician to turn over to a social service worker, no matter how noble a character she may be, the responsibility of informing the patient of such an important decision. Positive cases of tuberculosis are still not so numerous that the physician cannot find time to see them.

To sum up, I have tried to emphasize the following points:

1. A single x-ray examination of the chest, unsupported by other evidence, is never sufficient basis for an unqualified diagnosis of pulmonary tuberculosis.

2. Survey films should be used only as an indicator of the advisability of further examination with the use of standard-size films.

3. The advisability of attempting to report the presence or absence of calcification from survey films is extremely doubtful.

4. No individual should be informed that he has pulmonary tuberculosis except by a physician, and then only after examination with standard size x-ray films and correlation of the information derived therefrom with the history, physical examination, and laboratory findings.

ERYTHRODERMA DESQUAMATIVA*

(Leiner's Disease)

HAROLD E. STADLER, M.D.

BASIL K. BYRNE, M.D.

INDIANAPOLIS

We have observed two instances of a cutaneous disorder in infancy which can be classified as true erythroderma desquamativa. There is general agreement over the fact that the classical disease of Leiner's description is a rarity in this country. The syndrome as observed may often be differentiated only with great difficulty from pemphigus neonatorum (Ritter's disease) and from erythroderma desquamativa atopica. Septicity may be outstanding in the first two diseases.

Leiner[1] spoke of a generalized dermatosis marked by mild inflammation of the entire skin surface, desquamation of the epidermis and seborrhea of the scalp. This "peculiar universal cutaneous disorder" was seen in breast-fed infants and the mortality was 35 per cent. The reddened, scaling, crusted, and bullous skin involved the face except for the nasal and circumoral regions, giving a characteristic appearance. Leiner stated that this "autotoxic erythema" with the gastro-intestinal disturbance constituted the syndrome, and that it was necessary to differentiate it from Ritter's disease.

CASE REPORTS

Case 1: K. K. was born prematurely on March 7, 1946, and the birth weight was 3 pounds 5 ounces. She was cyanotic at birth, but responded quickly to oxygen therapy. The cause of the premature labor was a severe respiratory infection in the mother. One sibling, three years old, was well except for recurrent asthmatic bronchitis. Both parents, however, denied allergic disease of any type in the family.

A formula of acid protein milk was given with the baby doubling its birth weight at two months of age. On May 13, 1946, when the infant was nine weeks of age, she developed an erythema of the shoulders which rapidly spread toward the lower extremities. "Potato chip" desquamation developed at the shoulders, leaving a rough, dry skin surface. The desquamation followed the course of the erythema. On the fourth day of illness seborrhea of the scalp appeared and the abdomen became markedly distended, but gastro-intestinal symptoms were not noted. The liver edge was palpable to a normal degree. Fever was absent during the entire illness, and pruritus was minimal. Nikolsky's sign was not present.

The WBC was 13,900, and RBC 3,900,000 per cubic millimeter. The hemoglobin was 10 grams per 100 cubic centimeter of blood. The differential blood

* From the records of Department of Pediatrics, Indianapolis City Hospital, Indianapolis, Indiana.

[1] Leiner, C.: Erythroderma Desquamativa, *Arch. f. Dermat. u Syph. Bd.* **89**:65-76, 163-188, 1908.

count showed a lymphocytic predominance of 70 per cent and 2 eosinophils.

An evaporated milk formula was given and plain Lassar's paste used locally. On the seventh day of illness there was sudden development of generalized anasarca with weight gain of one pound. The edema disappeared in a period of three days and did not recur. The disease ran its course in eighteen days with complete recovery. The weight at birth was tripled at four months.

Case 2: F. C. W., a colored male child, was born on December 9, 1945, and his birth weight was seven pounds. His fifteen siblings were all living and well. The infant was breast fed and received orange juice from the time he was two weeks of age. About January 9, 1946, he developed a generalized skin rash which gradually progressed in severity. During the three days which preceded his admission (February 11, 1946) he had five convulsions.

The nutritional state on admission was excellent; weight was 10 pounds 12 ounces. The entire body was covered with "eczematoid lesions"; those on the scalp exuding a thick foul-smelling exudate. The lesions on the rest of the body were dry and marked by a scaling process. The eyelids were edematous. Itching appeared to be mild.

There was a moderate albuminuria and a mild glycosuria. The hemoglobin was 11 Gm. per 100 cubic centimeters of blood, WBC 10,950, RBC 3,160,000 for each cubic millimeter. The differential showed: neutrophils 23; bands 7; eosinophils 4; lymphocytes 62; and monocytes 4.

Two per cent salicylic acid ointment was used locally, and with a development of diarrhea soon after admission acid protein milk was given with no improvement in frequency or slimy foul character of the stools. Generalized edema developed with gain of one pound between the twelfth and fifteenth day after admission. Listlessness was marked. Nikolsky's sign was absent, and as the scales were removed by skin cleansing a rough, dry surface remained. Three to five green, watery-mucoid stools of foul odor were passed daily. On February 16, 1946, the temperature was 103°, with return to normal the next day. Ringer's solution was given by mouth. From February 21 to 24, 1946, the temperature ranged between 99.6 and 102.5 degrees. The condition of the patient was critical. Dehydration was treated by hypodermoclysis. On March 1, 1946, improvement began with complete recovery by March 25. The entire hospitalization period was six weeks, and the illness was present for ten weeks. The weight of the infant at the time of discharge was 11 pounds 8 ounces.

DISCUSSION

It would seem reasonable to conclude that Glaser and Markson[2] described erythroderma desquamativa atopica rather than Leiner's disease as a complication of infantile eczema. According to the classification laid down by Lewis Webb Hill[3], the allergic (atopic erythroderma) and non-allergic (Leiner's disease) dermatoses may be very similar as to cutaneous manifestations. Leiner's disease tends to occur in breast-fed infants, causes slight or no itching, and clears in a comparatively short time without recurrence. There is no allergic basis or complication of sensitivity nature. Eosinophilia is absent. Diarrhea is a common accompaniment and is regarded by some as necessary for diagnosis. Adenopathy is unusual and was not present in either of our cases, nor did we note blueness or clamminess of the hands or feet, to which Hill[3] called attention.

The rapid clearing of the disease in our two patients, the absence of eosinophilia and the early age of onset all favored Leiner's disease.

It is believed that dietary changes are not justified which will endanger the nutritional state of the infant, and this merely indicates that each case must be evaluated on the basis of the problem it presents. It will be noted that one patient developed the disease while taking acid protein milk; the other, a classically breast-fed, cleared while receiving the same preparation. The first patient manifested hydrolability of transitory character, which is difficult to attribute to hypoproteinemia since no substitutive therapy was involved in its rapid disappearance. In the second instance, protein depletion could well be the result of a selective injury to the (hepatic) mechanism of serum albumin elaboration.[4]

SUMMARY

Two cases of Leiner's disease are presented. One patient showed manifestations and course classically described by Leiner; the other infant conformed to the syndrome as generally observed in the United States. An allergic basis for the disorder does not seem plausible.

[2] Glaser, K., and Markson, S. M.: The Value of Serum Protein Determinations in Cases of Suspect Erythroderma Desquamativa, *J. Pediat.*, **26**:367, 1945.

[3] Hill, Lewis Webb: *Brennemann's Practice of Pediatrics*. Chap. 43, **IV**: I, 1944.

[4] Stadler, H. E., and Stinger, D.: A Case of Pick's Syndrome as the Basis for a Study of Hypoprotenemia, *J. Pediat.*, **18**:84, 1941.

GOING TO THE A.M.A. MEETING NEXT SUMMER?

If so, write now for your hotel reservations. See your A.M.A. Journal, or write to the State Headquarters for hotel information. The dates are June 9 to 13, inclusive, and Atlantic City is the place.

SARCOMAS OF THE UTERUS

J. WILLIAM HOFMANN, M.D.

INDIANAPOLIS

Sarcomas of the uterus are quite infrequent. They were first described by Meyer in 1860, and later confirmed by Virchow in 1867. In 1867 G. Veit, in his work upon diseases of women, described three cases of his own; one of the cervix, which was the first case on record. Altogether they comprise less than one per cent of all uterine tumors with variable estimates of six-tenths to one and eight-tenths per cent.

Relative frequency of sarcoma as compared to carcinoma has been studied by many observers: Geisler estimated that the proportion of uterine sarcomas was one to fifty; Krukenburg similarly estimated that there was one sarcoma to forty-seven cancers of the uterus; and some of the others varied from one to thirty-four to one to thirty-eight. The frequency with which sarcoma transformation occurs in myoma is a point of practical importance, while the relative frequency of myoma uteri and sarcoma uteri is purely of academic interest, and the estimates which have been made to compute this proportion are so conflicting as to be quite valueless.

With reference to the occurrence of sarcomatous change in myoma, Masson states that of 4,322 patients operated upon for uterine myoma at the Mayo Clinic, forty-four, or about 1 per cent, were found to have sarcomas. The above author also quotes Aschoff as having found the same percentage of sarcoma at the Freiberg Clinic. According to the figures of such men as Vogt, Krukenberg, Gessar, and Meyers there is a great preponderance of corporeal over cervical sarcomas. It is worthy of note that the proportion is very similar to that of corporeal and cervical myomas; whereas it is exactly the converse of that relation to corporeal and cervical carcinoma. They are most commonly found within the myometrium or intramural growths, and at times apparently within pre-existing myomas. Submucosal tumors are less frequent, and subserous ones are rare indeed.

Sarcomas of the uterus are usually comprised of homologous tissue; there may be very immature and indifferent elements, the round or spindle cell sarcoma, or less immature and better differentiated cells, the fibro- or leiomyo-sarcoma, or mixtures of both in all possible combinations.

All these tumors have cellular prototypes in the normal constituents of the uterine wall, but tumors composed of tissue which is foreign to the uterus may also occur. Heterologous tumors are less frequent than the homologous ones. They may be simple or complex. The former or heterologous tumors occur almost anywhere in the uterus, but are usually submucous. In this location is particularly the mixed cell type, which appears almost always as polypoid masses, hanging into the cavity of the uterus from a broad submucosal base. Intramurally these tumors are rare. Subserous ones are even more infrequent. This type of tumor elects the cervix much more frequently than the corpus uteri. A few of the heterologous tumors contain striated muscle, but whenever striated muscle cells appear in the uterus it is usually in association with a complex submucous botryoid form. Rarely, indeed, do they appear as simple rhabdomyomas or rhabdomyosarcomas.

Sarcoma of the uterus appears most frequently at about the climacteric. It is now recognized that a myoma may exhibit three distinct types of malignancy. These take the form of (1) malignant leiomyoma, a very cellular growth composed of young, unstriped muscle cells and capable of producing metastasis, although not histologically malignant; (2) sarcoma formed from muscle cells by malignant metaplasia, and also sarcoma formed from the intermuscular connective tissue; and (3) endothelioma and periendothelioma, that is, types of sarcoma of lower malignancy arising from the blood vessels and lymphatics of the myoma. The naked-eye appearance of sarcomatous areas in a myoma is often sharply defined, owing to the cut surface being homologous and not whorled as it is in myoma. The malignant area is usually yellow in color and soft in consistency. Portions of the malignant tissue may become cystic and hemorrhagic. The sarcomatous change usually starts in the center of the myoma.

Whitridge Williams gave the proportions as round cells, 30 per cent; and mixed cells, 35 per cent. The proportions given by Weil in his inaugural dissertation are as follows:

(1) Spindle cells (seldom pure, but mostly preponderating) 35 per cent.

(2) Round cells, 40 per cent.

(3) Mixed cells, 25 per cent.

Uterine sarcoma may remain quiescent, growing very slowly over a long period, and then rapidly developing. It may subsequently produce widespread local extension of growth, pushing towards the peritoneum and into the parametric tissues, also becoming submucous and distending the uterine cavity. In the latter case the uterus may express portions of the growth through the cervical canal in the form of polypi. True metastasis in glands and distant organs may occur, but the manifestation of malignancy occurs later with sarcoma than with carcinoma. The transference of sarcoma elements to a distant organ takes place by both blood stream and lymph stream. Emboli have been found in pelvic and pulmonary veins. In combination growths the metastasis is usually entirely sarco-

matous. Most recurrences after operations are local and regional; secondary deposits are relatively uncommon, so that if the local growth can be completely removed the prospect of cure is better than in case of epithelioma and adenocarcinoma. Physical examination will reveal a uterine tumor which in a large percentage of cases will be regarded as a myoma. To the triad of usual symptoms of hemorrhage, discharge, and pain must be added, because of the large size which sarcoma may attain, that of pressure on neighboring organs. Another obtrusive sign is early cachexia. The symptoms accompanying growth, the site and pathological anatomy of which is so variable, must of necessity also vary. Noting that many sarcomas develop within a myoma, and also that the majority of mural growths are circumscribed and more or less encapsulated, it will be understood why an absolute diagnosis is frequently impossible. Whenever a myoma shows signs of degeneration, especially after the menopause, (when a healthy myoma should be quiescent) it should arouse suspicion of sarcoma. Similarly, if ascites supervenes in the case of a myoma under observation, and if a patient becomes cachectic and loses weight the evidence is significant of malignancy. Sarcomas of the endometrium have to be diagnosed from corporeal cancer and from submucous myoma, and here it must be remembered that when there is a uterine tumor, plus irregular hemorrhages after the menopause, the case is much more likely to be one of myoma and corporeal cancer than sarcoma. In elderly subjects senile endometritis with retention of pus may clinically simulate a degenerated sarcoma. Tubercle and chorionic cancer may also resemble a sarcoma. All polypi removed from the body or cervix must be examined histologically. In diagnostic curettings a deep intramural growth may be entirely missed, while scrapings obtained from a combination tumor may be carcinomatous. Carcinoma of the cervix may by the naked eye also be indistinguishable from sarcoma.

The prognosis in rapidly-growing sarcoma is very grave, indeed. Especially is this so with angiosarcomas, all of the recorded cases of this type having produced metastasis (Weil). The outlook would appear to vary according to the type of cell which makes up the bulk of the growth. Spindle-celled, fibro- and myo-sarcomas are apt to grow very slowly. The round-celled growth is to be regarded as the most malignant. Grape-like sarcoma of the cervix is very malignant. The duration is difficult to gauge because it is hard to determine when a sarcoma begins to develop within a myoma. The average duration of life has been placed from two and one-half to three years.

Death results from cachexia sepsis and recurrent hemorrhage, and in some cases is hastened by metastasis, pressure effects, and the breaking down of the tumor.

The early and prompt removal of the uterus and its appendages should be carried out in all suspected cases. The extended abdominal operation with the cervix enclosed in a vaginal cuff is the wisest technique to employ when dealing with a soft tumor occupying the cavum uteri. It is as important to explore for enlarged parametric and iliac glands as it is to do so when operating for cervical carcinoma. Cases too advanced for surgical aid may be given a full dose of radium, followed by x-ray. It seems to be a recognized fact that sarcomas are more susceptible to radio-active bodies than carcinomas, but it also must be admitted that the use of radium is not free from danger.

DOCTOR URGES REHABILITATION FOR CONVALESCING PATIENTS

The convalescent period of sick or injured patients should be utilized for rehabilitation, according to Rex L. Diveley, M.D., of Kansas City, Missouri.

Writing in the current issue of *Occupational Medicine*, published by the American Medical Association, Dr. Diveley feels that "too often the patient who has experienced a serious illness or who has had a cast or splint removed is left to his own devices to find his way back as best he can to his original state of health and vigor."

This problem was especially serious during the war, the author states, when a "soldier fully recovered from his illness was too often allowed to lie around the hospital wards until he felt that he was able to return to duty. Even after a protracted convalescence a large majority of the patients, when they returned to their units, found that they were neither mentally nor physically fit to carry on at the pace demanded of them. . . . In consequence, hundreds of military personnel were turned back through the hospital system as unfit for duty, although they had fully recovered from their acute illness or injury."

Dr. Diveley and his colleagues were commissioned to set up a system of supervised convalescent care in the European Theater of Operations in an attempt to deal with this problem.

"A small rehabilitation center was established in the spring of 1943," the author states, "and by trial and error a system of treating convalescent military personnel was built up which cut down the man-power days lost to the army approximately 50 per cent. . . .

"When VE day came, a program of rehabilitation had been established in each of the general and station hospitals, and in addition five rehabilitation centers exclusively for the reconditioning of military personnel were functioning. Over an eighteen month period 70,358 patients passed through the five established centers, and, in addition, many thousands of men were reconditioned in the hospital system and returned directly to duty. . . .

"Of the 70,358 patients dealt with, 57.3 per cent were returned to general assignments and 27.2 per cent were returned to limited duty, a total of 84.5 per cent to duty, while 15.5 per cent were returned to the hospital for further treatment or for transportation back to the zone of the interior."

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3. **Restoration and preservation of our natural waters and resources.**
4. **Maintain the present high standard of the Indiana University Medical Center, combining the full medical course in Indianapolis.**
5. **Elimination of diphtheria and smallpox through immunization and vaccination.**
6. **Support of the state-wide campaign against undulant fever.**

Editorials

A Merry Christmas To All!

Again do we approach the Christmas Season, honoring the birth of the Christ Child, the "Prince of Peace." As the war years recede into the past we approach this Season with all due reverence; it is a time for remembrance, even a time for rejoicing. It is a time for families to again be reunited, even for a day. With most of us it also is a time for feasting, not necessarily a feast of viands and drink, rather a feast of remembrance.

Who has forgotten the Christmas of their early childhood, when Santa Claus was the greatest of the patron saints; who has forgotten the joys of giving as well as of receiving?

Yes, the Christmas Season is again headed our way; old Santa promises to outdo all his previous efforts; he wants everybody to be happy on this great day, the day that celebrates the greatest event in history.

So then, let us forget earthly cares, let us put aside all the petty things that may have been distressing us in the past. Let's enjoy the Christmas Season as never before.

THE JOURNAL wishes that all this may come to every member—A Merry Christmas!

THE INDIANAPOLIS SESSION

Balmy weather, unclouded skies, a general feeling of "I am glad to be here"—all these things combined to make the 97th session of the Indiana State Medical Association a record-breaker. The registration figures tell the story:

Member registrations	1,482
Woman's Auxiliary	355
Guests	250
Exhibitors	153
Total	2,240

This tops all previous records by a large margin, the record heretofore standing at something like 1,800. As a matter of fact, these figures are not complete; for example, it is estimated that a hundred or more women attending the dinner on Tuesday night had not officially registered. In addition, for some reason unknown to us, there always are several members who do not take time to register.

So it is that 1946 goes down in the history of Hoosier Medicine as its greatest; nor is this all—in addition to the record attendance, there is the matter of general interest manifested.

We have been attending these conventions for some forty years and never before have we noted a more intense interest in what was going on than at this meeting; every man and woman present wanted to get everything possible out of it—and did. The reunion luncheons were all of the capacity sort; the early breakfasts brought out unusual attendances, entertainment features played to capacity houses—in all, everyone had a good time, socially and intellectually.

The annual smoker was a huge success—we dare not try to estimate the attendance there. The "Hello, Bill," the "Hi there, Tom," along with other similar greetings, were to be heard all over the dining room of the huge Murat Temple. Good food and plenty of it was readily attainable, via the cafeteria method, while some half dozen attendants were busying themselves in opening bottles of the Gambrinic Nectar. Cigarettes were to be found at each plate—many of the old-timers preferring to draw on the trusty pipe for the evening.

While all this was going on the ladies were dining at the Athenaeum, just across the street, and from all reports they had a most delectable dinner.

Exhibit hall, crowded at all times, was "something to behold." Larger than ever in our memory, the exhibits were well displayed, new fixtures being used. Each was manned by several representatives, instead of the usual plan of having but one man in charge. And each of these chaps knew what he was talking about—readily answering all questions, giving demonstrations, and what not.

The scientific section meetings had unusually large audiences and several of the guest speakers remarked that the interest manifested was unusually high. And the scientific exhibit—well, it was the best we have seen. Right-up-to-the-minute subjects were portrayed in such a manner as to be understandable to all, the committee in charge of this work, headed by Dr. C. G. Culbertson, sure did themselves proud.

The speakers on the various programs were: *General Meeting*, H. Dabney Kerr, M.D., Iowa City, Iowa; Wallace E. Herrell, M.D., Rochester, Minnesota; Karl A. Meyer, M.D., Chicago; Stanley G. Garber, M.D., Cincinnati; Howard D. Fabing, M.D., Cincinnati; Walter U. Kennedy, M.D., New Castle. *Section on Medicine*, Brandt F. Steele, M.D., Indianapolis; A. N. Ferguson, M.D., Fort Wayne; Stanton L. Bryan, M.D., Evansville; Howard D. Fabing, M.D., Cincinnati. *Section on Surgery*, Karl A. Meyer, M.D., Chicago; C. O. Almquist, M.D., Gary; Ralph Morton Bolman, M.D., Fort Wayne; Cleon A. Nafe, M.D., Indianapolis. *Section on General Practice*, Stanley T. Garber, M.D., Cincinnati; George S. Bond, M.D., Indianapolis; James O. Ritchey, M.D., Indianapolis. *Section on Ophthalmology and Otolaryngology*, Mary Alice Norris, M.D., Indianapolis; Joseph Larmore, M.D., Anderson; Malcolm Miller, M.D., Goshen; Ernest L. Dietl, M.D., South Bend; Albert D. Ruedemann, M.D., Cleveland. *Section on Anesthesia*, Ralph T. Knight, M.D., Minneapolis; Floyd T. Romberger, M.D., Lafayette; William B. Adams, M.D., Muncie. Olin West, M.D., Nashville, Tennessee, was the scheduled speaker following the dinner, but was forced to cancel his engagement, due to illness. Thomas Hendricks substituted for Doctor West. N. K. Forster, M.D., Hammond, spoke to the Woman's Auxiliary at their luncheon meeting.

Section officers for 1947 were named as follows: Section on Anesthesia, Frank W. Ratcliff, Lafayette, chairman; William H. Lane, South Bend, vice-chairman; Edward F. Bloemker, Indianapolis, Secretary. Section on General Practice, Claude S. Black, Warren, chairman; Clay A. Ball, Muncie, vice-chairman; Eugene F. Boggs, Indianapolis, secretary. Section on Medicine, William M. Dugan, Indianapolis, chairman; Maurice E. Glock, Fort Wayne, vice-chairman; Stanton L. Bryan, Evansville, secretary. Section on Surgery, Arnold Duemling, Fort Wayne, chairman; William N. Wishard, Jr., Indianapolis, vice-chairman; Harold D. Caylor, Bluffton, secretary. Section on Ophthalmology and Otolaryngology, R. R. Calvert, Lafayette, chairman; Robert A. Smith, New Castle, vice-chairman; R. P. Good, Kokomo, secretary.

In the sporting events the 1945 "champeens" were crowned, as follows:

Dr. H. M. Banks, of Indianapolis, chairman of the Shoots Committee, reports the winners as follows:

Regulars: first place, Dr. C. M. Donahue, Carmel; second place, Dr. H. C. Adkins, Indianapolis; tied for third place, Dr. H. B. Cox, Indianapolis; Dr. Louis T. Need, Indianapolis; Dr. H. M. Banks,

Indianapolis; fourth place, Dr. John Lansford, Redkey.

Casual Shooters: first place, Dr. J. A. MacDonald, Indianapolis; second place, Dr. Murray N. Hadley, Indianapolis; third place, Dr. N. Cort Davidson, Indianapolis; fourth place, Dr. Marvin McClain, Scottsburg.

So, as we have said, 1946 goes down in our book as "the tops" year, presaging still greater things in the years to come and making it certain that the 1949 session, which means our 100th anniversary, will be so large that the problem of where to house all who attend will be a huge one. We long have been proud of the Indiana State Medical Association, that pride now having reached the bursting point.

EDITORIAL BOARD MEETING

The Board met during the convention, all but three members being present. Numerous matters connected with the publication of THE JOURNAL were discussed, probably the most important being that of a "Year Book." This matter had previously been discussed by the Board and at this session a final plan was adopted.

This number of THE JOURNAL will be published in January, 1947, and will be devoted entirely to what might well be determined an "economic number." It will carry the membership roster, not only alphabetically, but by county as well. In the larger areas of the State the street addresses of the members will be given.

In addition to this the number will contain an up-to-date copy of the Medical Practice Act of the State of Indiana, together with the State Board membership. A complete Board of Health official family will appear in the issue. The same may be said of the Dental Board, the Board of Pharmacy, the Board of Veterinary Surgeons. Also there will be a complete "lineup" of the Indiana University Medical Center.

The By-Laws of the Indiana State Medical Association will occupy a prominent place in this special number, as well as a briefing of various laws affecting the medical profession, this being done by Albert Stump, our attorney. The various laws relating to the office of County Coroner will be reviewed.

In addition to all the above there will be numerous other matters of general information that we are sure will be of much benefit to our members. It will be a number that we can keep before us at all times, obviating the necessity of searching about the office for information we wish at the moment, in many instances obviating the necessity of calling some one else for the desired information.

The idea originated from the "Blue Book," published annually by the Wisconsin State Medical Association. For some years they have published, early each year, such a number and have found it to be very popular and of vast interest to its membership.

We would very much appreciate your suggestions as to forthcoming numbers of the Year Book, since it is our plan to publish such a number each January. If you have any suggestions as to material that would be of general interest we shall be glad to incorporate such matter in future numbers. Watch for the Year Book, in January; keep it at your right hand and we are certain that you will find it a most informative addition to the handy books on your desk.

WHAT OF THE FUTURE?

The Indiana State Medical Association has indeed been fortunate in its selection of leaders, this for years past. But it seems to us that in more recent years we have been doubly fortunate in having at our head men, who, devoted to the principles of medical organization, have given their all in its furtherance. The war years were trying ones, but each problem was met, squarely, and it is now apparent that the proper solution was had.

But we would speak of the postwar years, referring to the last two years. It seems to us that our leadership during these trying years has been of an exceptional character. Fortunate indeed were we to have two men at the helm who are of the "grass roots" variety, meaning that they are general practitioners, country doctors, if you please. Both these men, Drs. J. T. Oliphant and Jesse Ferrell, are truly of the "garden variety" of practitioners; their long years in practice have been spent in the rural areas; they have met folk as no other group of doctors have met them; they *know* their patients well. They lived with them, sharing their joys as well as their sorrows—they were a part of the daily life in the communities in which they live.

We speak of these little intimacies, in that they have had much to do in forming the background they brought to us; it meant a complete understanding of the many problems that have been ours.

Now of the immediate future; we have two men "coming up" both of whom have long years of "apprenticeship." Doctor Romberger had his first official contact with the Indiana State Medical Association at the Marion session, in 1925. He likes to relate that as he sat in the House of Delegates that year he was much impressed by certain actions that took place, immediately deciding he would like to be a permanent part of our great organization. Not long after that he was named as councilor for his district, holding that position many years—until he was chosen as head of the Council. Here he did yeoman service, attending not only to the Council affairs, but being a regular attendant at all sessions of the Executive Commit-

tee—the latter a liberal education in medical economics.

Named as president-elect in 1945, he again took up the new task, with all the old vigor and earnestness of purpose that have characterized all his medical activities. He enters upon his new duties, as "head man" of Indiana Medicine, "rarin' to go," and he will do just that—he will "go," and go big.

Following him will come Dr. Cleon Nafe, just finishing a service of ten years as Chairman of the Executive Committee. For all this long time Nafe has had his hands full, has been a student of medical economics all that time, resulting in a vast fund of knowledge of the things in which we are most interested. We have attended many of the monthly sessions and have been impressed with the sincerity of its presiding officer.

Doctor Nafe, like Doctor Romberger, came up from the ranks; they both know what it is all about, and while in most instances they also know the answer, they are always seeking advice as to the best thing to do.

It may appear a bit odd to do this "preachment" before either of these men have held the reins, but we are cocksure of the end result. We are so enthusiastic about the future of Hoosier Medicine that we could not resist talking a bit about what the future holds for us. The record registration at our recent session was like the rejuvenation from a goat gland, or something similar; it was the best tonic we ever had had; *more than four hundred over any previous year*, making 1946 go down in a special page in our book.

With that number of folk interested in our future and with the leadership assured for the next two years, the Indiana State Medical Association will go on and on to higher things; we believe no problem will be insurmountable. You have the leadership—as you have had it in the past—and it is now up to the individual member to do a little pushing on the big wheel.

THE MEMBERSHIP ROSTER,

which usually is carried in this issue, will appear in the January issue of THE JOURNAL, which will be a special number—a Year Book—and it will contain an alphabetical listing of the members, as well as a listing by counties. An abundance of informative material also will appear in the Year Book. Watch for it!

Editorial Notes

The Indianapolis News, which paper evidently has been "listening in" on what we have been saying regarding the prevalence of brucellosis, recently carried an editorial on the subject entitled "Every Man's Disease." It was very well written and the average lay reader would be very much impressed by it. We are pleased to note that the Hoosier press is awakening to the dangers of this widespread disease and are beginning to talk about it. After all, we must get the general public interested before we can do the things we would like to do in the matter of brucellosis control.

In speaking of new hospitals, it might be well to recall that a survey recently made indicated that Indiana's shortage of hospital beds amounted to about 4,500. A map shows that there are at least three large areas within the State where hospital facilities are not available within fifteen miles. Even with modern transportation facilities, these sections should have better immediate facilities.

At the recent Indianapolis session it was brought to the attention of the membership that at the San Francisco meeting of the American Legion the following resolution was adopted (we do not quote the "whereases"): "Now, therefore be it resolved that the national assembly of the American Legion hereby expresses its opposition to compulsory health insurance."

The Veterans Administration announces that, since V-J Day, there has been an increase of 29 per cent in the number of veteran-patients in its hospitals and homes and in other hospitals under contract. The Administration also announces the scale of "pensions" for the widows and children of those who died as a result of War II service. Each widow receives sixty dollars per month, plus eighteen dollars for one child and fifteen dollars and sixty cents for any additional children.

The opening program of the dental survey, being conducted under the direction of the Indiana State Board of Health, is under way and it is expected that during the five-year period some 6,000 school children will have the benefit of this service. It has been said that not more than twenty per cent of our children have, normally, the advantages of regular dental care. The cost of the program will be met by the United States Public Health Service, the Indiana State Board of Health of Richmond, where the program is under way.

A delay of sixty days was granted in the hearing before the State Medical Board of charges against Dr. Charles P. Kaadt, South Whitley, charged with operating an institution for the "cure" of diabetes.

At long last the Indiana Association of Licensed Nursing Homes has adopted a form of case history records, this to be uniformly used in all legitimate "homes." This plan was adopted at a recent meeting of those concerned, held in Indianapolis. Doctor William F. King, head of the Department of Geriatrics for the Indiana State Board of Health, suggested that the State set up two nursing homes, one for the normal aged, the other for mental cases, these two homes to serve rather as a demonstration of just what nursing homes may do in furthering matters of health.

Dr. F. S. Crockett, of Lafayette, and chairman of the A.M.A. Rural Medical Service Committee, announced at the Indianapolis session that rural hospital aid is to come within a short time. For a long time Doctor Crockett has been active in this work, meeting with local Granges and other farm groups and a few months ago called a meeting of those concerned, which was held at Purdue University. The medical profession, long aware of the need for more adequate medical care in many rural communities, could do little about it, of themselves, but now have enlisted support from many quarters and some real accomplishments appear to be coming in the near future.

One of the proposals for raising additional State revenues is a cigarette tax of three cents per package; comment regarding this is to the effect that the State now has a large surplus and additional taxes would seem out of order. However, if the plans of the administration are carried out much of this surplus will be used for new buildings, all of which seem essential. In our State Hospitals, for example, there are many buildings that should be replaced and many other new ones constructed. Then, too, we have additional hospitals to consider. The Governor has suggested that in the event a cigarette tax law is enacted the monies therefrom, variously estimated at around five million dollars per year, will be expended on our health program. It is pointed out that the majority of states now have a cigarette tax and once the smoking public "gets used to it" there will be little objection. We of course are in favor of most anything that will enable the authorities to carry out the most extended health program that Indiana ever has seen.

Word comes from Greenfield that Hancock County had approved a referendum vote, at the general November election, to determine if the people of that county want a county hospital. This is just another of the many instances in which Indiana folk are interesting themselves in county hospitals. We predict that in the next few years many such institutions will be built and that ere long most Hoosier residents will have available modern hospital facilities.

The Board of Health program, which probably should be termed the "Council of Public Health," is all set and ready to be presented to the 1947 legislature. Briefly, it involves a drive for full-time county health officers, an extension of the tuberculosis "screening" program, a composite study of brucellosis, a child dental health study, and some of the problems of geriatrics. It should be borne in mind that this Council comprises some forty-five members, from all the professions, trades and businesses in our state, and has the support of the administration.

For a time it looked as though the Hoosier tomato crop might be somewhat of a failure, when along came Dame Nature to the rescue. Now the story is different; we never in our history had such a crop and as late as the first week in November there were tomatoes being harvested. And the quality is tops, so that Indiana still stands at the head of all the states in the production of tomatoes, and her product is generally accorded as being of the highest quality. In our own, little, backyard tomato-patch we did very well, gathering the last of the crop as of November eighth.

A move is on the floor to increase the annual appropriation of the Commerce and Public Relations Department of the State of Indiana. Lieutenant Governor Richard T. James, ably abetted by Director Paul M. Ross, plans to ask for an increase from $20,000.00 a year to $125,000.00. In recent years this fund has been increased to $65,000.00, due to donations by private individuals and manufacturing firms. Indiana can well afford to spend some *real* money on such a program and should not depend on donations. Other states spend a sizeable sum each year in telling folk over the country about the desirability of locating their businesses in Indiana, spending vacations in our widely-known State Parks, etc. New York, for example, spends a million dollars a year in such propaganda, while Michigan spends a half million a year, just to advertise its recreational facilities. Pennsylvania also spends a million annually. *Indiana had been putting out twenty thousand dollars for such purposes!*

President's Page

This being the last article that I shall write for the President's Page, it should cover quite a large field in regard to Association activities. Credit must be given to all our members, in that they have assisted in every way possible to make this passing year so successful. Our special committees have functioned unusually well, and by so doing have produced the greatest Indiana State Medical Convention that has ever been held. For all of this I am deeply grateful, and wish to thank one and all who made this possible.

In assuming command of one of the ships of American Medicine one assumes a great responsibility. Our own ship, Indiana Medicine, is an integral part of the great Armada of American Medicine. This ship has been commanded by men of great ability, and has always been steered on a course with which few could find fault, and therefore has never been wrecked upon the rocks of some uncharted sea, such as selfishness and greed, but has been kept on a straight and true course, for the benefit of all, in a wise and able manner. At times, the cargo of this ship has been heavy and unwieldy, but by judicious action of our commanders, it has always been delivered at the proper time and at the place designated.

In order to make our ship, Indiana Medicine, an efficient, integral part of American Medicine, the commander must select a crew. These men so selected must be willing to work at their particular jobs. This, I have found, was a very pleasant affair, and I am safe in saying that not one who was called upon shirked his duty. It makes me happy to report that your ship is still on an even keel, and will continue to deliver its cargoes. Your new commander will soon take helm, and I predict for him greater things, in that he will be able to deliver larger and more important cargoes, because the concerted action of the whole Armada of American Medicine has taken on a very significant co-operative effort, in that we can sail together with a planned ideal to achieve, and the sea on which we will be compelled to sail our ship is now a correctly charted one. As we now move as one unit there is less likelihood of being cast on the rocks, which heretofore have almost wrecked every effort that was put forth to carry our ideals to a safe landing place.

What were worries in the immediate past I think can be written off, with much joy, because of the turn of events in the past month. The subversive elements, which are always our enemies, are not licked yet, but we are in so much better position to defend ourselves, and if we do not assume an attitude of complacency again, I, for one, do not think we have much to fear.

The achievements of the past year are an open book, and it is the hope of every Indiana doctor that the progress that has been accomplished will be only stepping stones to better things to come, and I can, without any reservation, predict that the greatest era of Indiana Medicine, as well as of American Medicine, will be unfolded under the leadership of our well-trained officers-elect. Upon their shoulders rests a great responsibility, but with their special training in the past, and with known ability to solve any problem that presents itself, I am sure we can all feel very secure.

With these thoughts of good will to my successor, I think the words of the poet are very applicable: "Thou to sail on, O Ship of State! Sail on, O Union, strong and great! Humanity with all its fears, with all the hopes of future years, is hanging breathless on thy fate!"

So with this I bid you, not good-bye, but just "So long."

J. E. Farrell

Convention Notes

We just can't get over that total registration—over two thousand! We cannot help but wonder what we are going to do about it if this thing keeps up. Someone was unkind enough to suggest that the Auxiliary have their own convention, since the increase in registration of women has exceeded that of the men. We just can't see this; the women folk add just the right bit of color to our annual gatherings; they look after themselves, so what?

The House of Delegate's breakfast meeting was held at 7:15, thus upsetting a very old tradition—such meetings *always* having been held right on the dot of seven. Inquiry developed that some of the young bucks had objected to such an unearthly hour and the 7:15 was a sort of a compromise. As it was, several came straggling in, looking as though another hour or two of "shut eye" would have helped some.

One of the men in charge of an exhibit voluntarily made this comment to us: "I want you to know, and I mean it, that in all the medical conventions I have attended in several years past I never have seen a more distinguished body of gentlemen." We were convinced that he meant what he said and, on behalf of all you "distinguishees," we thanked him, most heartily.

About the only thing needed to have made the annual smoker a perfect Babel was a tower—everything else was there. Get about a thousand men in a non-sound-proof room, give them a little ambrosia and a smoke, after a snack, and they get going, good. A thousand women storming a nylon sale would not have produced a better sound-effect.

It's odd, what you will see at times from your hotel or club window, of a morning. One morning we noted a man, apparently of middle age, clad only in shorts, with a mirror on a chair in front of him, grooming his hair. He first rubbed in what we took to be a lot of bear grease, then began combing and brushing. Apparently the job was not well done, as he again mussed up his locks and started all over again, combing his hair *back*, too, which to us meant that he had a bit of alopecia toward the rear. After about four essays he evidently decided the job would pass, so went on about his dressing. He was just a normal man, after all, as we noted that he put his pants on, one leg at a time.

Never saw so many of the younger group in attendance at one of our annual sessions, most of them of the GI variety, too. It is just as well, for one of these days these chaps will be taking over. We wish them every success when that day comes.

A note from Dr. and Mrs. Joseph Skobba says "These two Hoosiers sure are sorry to have missed the convention." Joe has located in Atlanta, where he will practice psychiatry. Mrs. Skobba will be remembered as Hope Toman, better known as "Miss JOURNAL," through her connection with our magazine for some twenty years.

There is too much "double-talk" at some of our committee sessions. The boys thresh out a subject, the chairman announces another, and the first thing you know someone wants to get back on an old bone that has been thoroughly masticated. Then they start all over. Jesse Ferrell set his foot down on such doings; when a matter had been disposed of, that was that.

For the first time in years Bill Wishard failed to snap our picture; his alibi was that his camera went out of commission before he got around to us. However, he told us he had quite a few pictures, many of which appear in this issue of THE JOURNAL.

Did you notice the "special" badge worn by Tom Hendricks? It was gotten up by the headquarters girls, who spent no little time in its creation. In addition to the ordinary badge it carried red, white, and blue streamers—a very ornate thing. Reminded us of the "first premium" award pinned on the *male* Percheron at the Indiana State Fair.

Gordon Batman, general arrangements chairman, told us of the setup the Indianapolis group has for planning a meeting. There is a committee of some fifteen members, each definitely in charge of a particular phase of the convention. In turn, these men have sub-committees. Practically all the work is carried on via telephone. The head committee decides something should be done and the proper man is given the assignment. He gets on the phone and tells his own group what is to be done, and that is that. They also are training a younger group for future activities, which we believe to be a very good idea.

When Jesse Ferrell calls for order he gets it, right now. Not in many years has a presiding officer managed to put through a large grist of business in such short order, yet giving plenty of time for *necessary* discussion.

A. S. Jaeger, "out of commission" for a few months due to an illness, is again back on the job and was very much present at the convention. His illness in no wise affected his speech apparatus, since he remains a rather voluble—but interesting—talker.

There was an extraordinary agenda before the House when it opened its first session, Tuesday afternoon, but with reference committees already named, and Jesse Ferrell presiding, it was a matter of but a short time until the decks had been cleared and the House had adjourned. We have but one suggestion in this matter; when a member is advised that he is to be named on a reference committee and he learns that he will be unable to attend he should at once notify the Executive Secretary. Time was when even the first session of the House carried on for a matter of several hours, on one occasion there was called an extra session, all of which could be avoided if pre-session plans were carried out.

Olin West, "The Sage of Tennessee," sometimes yclept "The Tennessee Squirrel Shooter," was unable to keep his appointment as dinner speaker at the annual banquet, due to illness. We regret his inability to attend, since we would like our Hoosier folk to have met him in person. He is known to many of us and we all have a high admiration for the man and his work in organized Medicine.

When word came that Olin West would not be able to be present at the annual dinner the local committee was put to it to find some one to take his place. As usual, the matter was laid in the lap of the Council. Tommy Hendricks happened in at the session and was asked to give suggestions as to whom else might be gotten there in a hurry. He suggested several of the A.M.A. "brass hats" but was not certain that any of them would be available on such short notice. Up rose Cy Clark, the irrepressible. Says Cy—"I see no reason to be concerned about this thing; we have the man right here in our midst; being here, we do not have to pay his railroad fare, and since he is on an A.M.A. expense account, there will be no hotel bill to pay. I suggest Tommy Hendricks for the job." There being several members of the Council of Scotch descent, that settled the matter, then and there. It might be mentioned that Cy predicated his invitation on an agreement by Tommy to get his hair cut before the banquet.

When Hauss, the chap from New Albany, sets out to make a speech he makes it, willy-nilly; it is just as well to let him go until he has finished. In one of the Council sessions, "Mitch," being pushed for time, tried to put a time limit on a certain discussion, but Hauss went right ahead and had his say.

Dan Urschel, from Mentone, took time out to attend the meeting, looking a bit into the undulant fever situation, and at the outlook for its ultimate control. Dan, as you will remember, is one of the real Indiana pioneers in the study of this disease and has given us some very valuable information on the subject.

Carl McCaskey, whom we have known for ages, was just bubbling over when we got to town. We knew that, sooner or later, he would break down and tell us just what it was all about. Later during the meeting he confided that he had been named as president-elect of the American Academy of Ophthalmology and Otolaryngology. This is the first time the honor has come to Indiana and we accordingly congratulate Carl.

Here's a little, merited tribute to Ray Smith, our new Executive Secretary. This was Ray's debut as *chargé d'affaires* of a State convention and he did a darn good job of it. We managed to get about quite a bit, checking up on what was going on in the various formal meetings, committee conferences and whatnot, and found not one instance in which every detail had not been planned out well ahead. Some one said, "We want some blackboards." Ray came back with the information that he had them, right on the spot. So it was with about everything else—when something was needed Ray had it available. He seemed to know all the answers and several times during the session we heard very complimentary remarks about his ability to do the right thing at the right time.

We had a little chat with a down-state member who is the fortunate possessor of *three* farms, down in Johnson County. Says his corn averaged a hundred bushels to the acre and his other crops in proportion. He does not sell a single ear of this corn, in fact he usually buys a few thousand bushels, all of which is fed to the live stock. Gave us quite a bit of information about Duroc and Hampshire pigs, among other things stating that "Hamps" made better mothers, hence he crosses them. One astounding thing he told us was that pumpkins were selling at the canning plants at *twenty dollars per ton!* We recall when two dollars was considered a high price. Look out for the increased cost of pumpkin pie this winter!

George Garceau, in presenting the name of Cleon Nafe for president-elect, made a most convincing speech. It is just as well that there were no other candidates, as George's "argument" was so convincing that no one else would have had a chance.

Rollis Weesner, Executive Secretary of the Lake County Medical Society, had an assignment on the Auxiliary program. We did not get over there to see how we was doing, but an agent tells us he told 'em.

One of the real old-timers we had missed at recent conventions was "Beecher" Sims, of Frankfort, who was being piloted about by George Daniels. Doctor Sims, 85 years young, graduated from Rush Medical College, in 1884, and has been in active practice in Frankfort throughout his professional life, though he retired about one year ago. It is good to see these oldsters drop in on us—shows their interest in the profession still is very much alive, even though they do not get about as lively as in former years.

Speaking of oldsters and those not quite so old, it is interesting to see old cronies get together at the smoker, light up their pipes, and sit down for a long chat. Among those noted were Drs. John Iddings, Crown Point, and George Douglas, Valparaiso. Evidently they had much to talk about, since their confab lasted most of the evening.

Earl Cripe, from up around Bremen, dropped in for his first convention since "service days." Wanted to know where son Jim might be found; told him Jim was in the State of Washington, and at once Earl began to plan a trip out there with some of his cronies. Seems they were classmates, 'way back in 1939.

Tommy Hendricks, by unanimous vote of the Council, was formally invited to attend the 1947 session, at French Lick; this without any commitments. Tommy insisted that the latter provision be inserted; said he wanted to be "on the loose" and not have to bother about short-notice speeches. This will leave him free to take his daily walk over the "loop," visit Mr. Brown when he feels a hunch, and do a lot of the things one likes to do when at French Lick. By the way, did you ever essay a walk with Tommy—well, it is not a walk, it is a canter. With arms and legs flying to the four winds, he makes it impossible to keep up with him. Also, he always wants to talk, and on the few occasions we have tried to walk with him we were so short of breath we could not keep up our part of the conversation—about all we could say was "uh-huh."

The hotels and clubs were filled to the brim; we were told that transients had a task of it, trying to find a room, during the week of our convention. Their dining rooms were crowded, as were the restaurants and lunch rooms about town.

We had our seventy-first birthday on Thursday, the last day of the convention. Had said little about it but somehow Jesse Ferrell got wise to it, and at the final meeting of the House that morning, said to the House members, "I now have a special announcement; today is the seventy-first birthday of our editor." Thereupon the whole gang arose and, led by little Charlie Combs, sang "Happy Birthday to You!" Dog-gone if it didn't kinda get me!

Speaking of Charlie Combs, we had forgotten just how long ago it was that he was elected as secretary of the Indiana State Medical Association, so we looked it up. It was in 1910, at the Fort Wayne meeting. Not long after that Charlie put in some innovations, one being a card index of members, the other the invention of the triplicate receipt book, still in use after thirty-six years.

Again speaking of old times, as we sat in the Council session we recalled some of the older men who, many years ago, were stand-bys in that group. We have forgotten how many years ago it is since we first sat in the Council, of which we were a member for many years, serving for some time as Chairman. Names that came to us were Drs. William Niles Wishard, Sr.; G. W. H. Kemper, of Muncie; Chas. B. Stoltz, South Bend; Graessle, Seymour; Mile Porter, Sr., Fort Wayne; Ed Walker and A. M. Hayden, both of Evansville; and many others whose names escaped us for the time. These men had much to do with association affairs and were among the builders of this great organization.

Something will have to be done about the matter of banquet reservations; try as we may, give the matter full publicity, have the girls at the registration desk ask if the registrant is to attend the dinner, there always are many who show up for the dinner without tickets. It is estimated that over three hundred were to be listed in this category this year, many of whom seemed mightily perturbed when advised they would be taken care of later, if additional room could be found for them. One chap was almost belligerent about it. An old-timer, a man with much experience in such matters, has suggested that due notice of the dinner be given in several numbers of THE JOURNAL and that those who expect to attend shall mail in their reservations, together with a check covering the cost of the tickets.

We are looking forward to Dr. A. C. Yoder's convention report which he annually makes to his home society, Elkhart County. We have read these for some years and find them the most comprehensive society reports we ever have read.

For the first time in many years we failed to hear the encouragement commonly accorded to the "galloping dominoes." Usually, some time during the smoker, someone exhibits a pair of dice and the raucous din begins, but not at this session. Probably in the "quietude" of some hotel room the addicts got together, but we heard nothing about it.

Hats off to petite Mrs. Petronella, of East Chicago, President of the Auxiliary. That little woman did herself proud, directing the affairs of the organization in a manner exciting the admiration of all present and, with her charming manner, carrying on her multitudinous duties with a marked ability.

Bob Doty, of Gary, brought his campaign for election of County Coroner down to the convention. Seems as though it helped some, since he was elected by a good majority, even though he was on the Democratic ticket and at a time when the "Demos" were being ruthlessly slaughtered, all over the country. Probably in 1948, other candidates having remembered Bob's successful sortie into our meeting, will want to do the same thing, necessitating a "campaign booth," where all can do their stuff.

THE JOURNAL definitely is not in politics, yet we all must recognize the fact that "the people have spoken" and that in the speaking they may have said something regarding the attempted regimentation of the American people.

Bruce Stocking had rather a hectic time in getting his reference committee report before the House and in finally having it adopted. His committee had one of the largest assignments, since many of the committee reports were lengthy and required much study and discussion. However, he came through with colors flying, the House finally adopting most of his report.

For a good many years we have been "feuding" with Crockett and Sensenich, most anything sufficing to start a small civil war. However, we have just about run out of disputed matters, so at the close of the convention we held a little conference and decided to go along amicably from now on. However, we will take some precautions, we will not throw away all our ammunition for some time yet. Never know what these dudes have up their sleeves.

Tommy Hendricks has not yet found a Chicago apartment, so Peggy remains at Maxinkuckee for the time being, the daughter being in Vassar. Tommy "commutes" over the weekends, Peggy meeting him at Plymouth.

Ray Elledge, President of the Lake County Medical Society (ever hear of it?), came in to breakfast quite late. However, by some hook or crook, he managed to be served and we noted that he got *two* rashers of bacon, instead of *one*. Know what a rasher is? It usually means two slices.

J. William Wright—one of these days we are going to call him just plain "Bill"—still holds forth as the "arbiter elegantiarum" in the matter of men's dress. One convention day he appeared in an "Alice Blue" outfit that was a knockout. We know of no other man who would essay such a "gown," but somehow or other he gets away with it.

Our Mama was so intrigued with Cy Clark's stories, particularly the one about "Fer Gawd's sake, don't dig him up," that she intimated she would like to go down to Indianapolis and spend at least a half day, just listening to Cy talk. Incidentally, did you ever note that when Cy tells a story his neck swells up and his face gets red? We at times have feared that he was working up to a first-class stroke.

The buffet supper provided for the smoker was one of the best we ever have seen; good food, plenty of it. We were not at all surprised to find beef brains, fried, on the menu, since this bit seems to be a general favorite in the Capital City. We recall, before the war, talking with the proprietor of the Saratoga, a tavern and sandwich spot, down town. He told us that he served *a thousand pounds of brains, every week.* No wonder Hoosiers are highly intellectual and do a lot of writing, what with all these added brains.

We talked with a number of our exhibitors, all of whom were pleased with the arrangement of the exhibit hall and the interest displayed by our members. This year there was an unusual number of the women folk who made the rounds, signing up for literature of things of interest to them and, of course, getting the free samples. One of the milk companies had established a milk bar, which was very well patronized, while at times it was almost impossible to get near the "coke" bar, where everything was free. Reminded us of the free Budweiser at an A.M.A. meeting, in St. Louis, a few years ago.

Never saw finer weather than that dished up for the Hoosier Medics. Not until the last day, after the final session of the House and of the Council, was there a bit of rain. In fact, it was a bit too warm at times; at one Council meeting the boys took off their coats, galluses to the contrary notwithstanding. "Mitch" got all excited at one stage and suggested an executive session, "where we can all take down our hair and do things!"

Passing a down-town barber shop one morning, we noted quite a commotion inside and stopped to see what it was all about. There was a group of our own members, all gesticulating and all trying to talk to the boss at the same time. Ross Sensenich seemed to be doing most of the talking. After a bit we discovered what brought about such a commotion. It seems that this group had gone in for a haircut and were quibbling about being charged a dollar for the service, when not a Man-Jack of 'em had any hair to speak of. In addition to Sensenich, we noted Rozelle, Hauss, Scamahorn and about a half-dozen others in the group of revolutionists. One of them offered to compromise, asking us to be the arbitrator—we declined on the ground that we did not have enough hair of our own to act fairly in such a matter.

A new speech-recording device was used at several of the meetings, particularly at the House sessions. Some of the boys were a bit chary about the contraption, George Daniels putting up quite some resistance when Jesse Ferrell "ordered" him to step up in front of the machine. George averred that he did not want to be put on record—did not like the looks of the infernal thing. However, before the session ended, George, when he wanted to talk—which was just as often as usual—marched right up to the machine, like the good little boy that he is. While we are on the subject of George, we might as well complete the notes we made concerning him during the convention. First off, he was late in arriving; usually he gets in two or three days in advance, but we did not espy him until Tuesday morning. But, once on the ground, he took care of his duties very nicely, though there were two or three occasions when he was a bit slow in "Moving the nominations be closed and that the secretary cast the unanimous ballot." George finally got a bit peeved about it and warned that such further offense might cause trouble. From then on George was the official "I move you" guy.

Doctor Malouf, from up Peru-way, became quite reminiscent, in a chat with him. A long time ago he served as an intern at our local hospital, and he asked us if we remembered his foreign protein experiments, using boiled milk in this work. This was some thirty-six years ago, a long time to be remembering such details.

Ran into Bruce Lung and Charley Adams, both of Kokomo, at the smoker. Just hadn't seen Adams for some time and were a bit disappointed. Long time ago, when we first knew him, we predicted that when he got his "age spread" Charley would be a little, round, roly-poly sort of chap, he being of somewhat diminutive stature. But, lo and behold! There he was, still the slender chap whom we knew for so many years. Bruce opined that he was wondering what had become of our references to our native part of Indiana, Wild Cat; said he enjoyed these little mentions of that once-thriving community. As a matter of fact, though much younger than we, Bruce was "born and raised" just about a hop-step-and-a-jump down the road from our place, hence is quite familiar with all the old haunts.

We used to look for convention hats, of one sort or another; for many years "Bunny" Hare managed to dig up the darndest contraptions, while "Davey" Crockett wore one that he used when in medical school. Several others had head gear worthy of mention of some sort. But this year, probably due to the balmy weather, few hats were to be seen, so we had to look up something else to write about. It is neckties! For many years the middle-age and over-middle-age physician wore a necktie of modest color, commonly just one color. This had been true for so long that we had come to be a part of this program. We left home Monday morning, equipped with a supply of plain blues, browns and greys, feeling confident we would be able to get in the parade with anybody, so far as ties were concerned. Much to our consternation, RED is the official color for members of the Indiana State Medical Association. We made a count, at the smoker, and found nine out of ten members wearing red ties, regardless of their age. Noting this, we hiked right out next morning, to get a supply of reds—and did we get 'em? We DID!

A.M.A. PLANS FOR CENTENNIAL SESSION

Arrangements are being made to make the A.M.A. Centennial Session, at Atlantic City, June 9 to 13, 1947, "one of the greatest and most interesting medical assemblages ever convened." Each scientific section will feature a distinguished speaker from abroad. June 8 will be a special public health day. A religious program is being arranged. The President's Reception will be one of the many high lights of the Session. PLAN TO BE THERE!

The State Meeting

In Pictures



Dr. Floyd T. Romberger of Lafayette, Dr. Charles N. Combs of Terre Haute and Dr. Cleon A. Nafe of Indianapolis.



Dr. G. H. Wisener of Richmond, Ernest Rupel of Indianapolis and Bernard D. Ravdin of Evansville.



Dr. George Daniels of Marion, Dr. Harry P. Ross of Richmond, Dr. Raymond C. Beeler of Indianapolis and Dr. C. H. McCaskey, also of Indianapolis.



Dr. H. O. Mertz, Dr. Rollin H. Moser and Dr. Charles F. Thompson, all of Indianapolis.



Dr. Bert E. Ellis of Indianapolis.



Mrs. Wendell A. Shullenberger, Dr. Shullenberger and Mrs. William Niles Wishard, Jr., all of Indianapolis.



Dr. Robert A. Cornell of Crawfordsville, Dr. James F. Balch of Indianapolis, an unidentified doctor, and an unidentified exhibitor.

Miss Elsie A. Reid of headquarter's o and Dr. Herman M. Baker of Evansv





Dr. Roy V. Myers and Dr. Walter F. Kelly, both of Indianapolis (above center)



Dr. and Mrs. M. A. Austin of Anderson and Dr. Jesse E. Ferrell of Fortville.



Dr. Walter L. Bruetsch. Dr. Earl W. Mericle and Dr. C. Basil Fausset, all of Indianapolis.



Roscoe L. Sensenich of South Bend and Dr. George V. Cring of Portland.

Dr. H. G. Hamer of Indianapolis and Dr. N. K. Forster of Hammond.





Dr. Gordon W. Batman of Indianapolis and unidentified visitor (Above, center).



Mrs. Karl M. Coons and Dr. James N. Collins, both of Indianapolis, and Mrs. David A. Bickel of South Bend.



Dr. E. M. Glaser of Brookville, Mr. Thomas A. Hendricks of Chicago and Dr. Will A. Thompson of Liberty.



Dr. Robert Howell of Indianapolis and unidentified exhibitor.

PHOTOS THROUGH COURTESY OF DOCTOR WISHARD

Readers of THE JOURNAL are privileged to enjoy these pictures through the kindness of Dr. William Niles Wishard, Jr., of Indianapolis. He took the pictures here and there during the two-day state meeting and gave them to THE JOURNAL with his compliments. We are grateful for Doctor Wishard's thoughtfulness, and wish to publicly thank him for his fine contribution to this issue.

—The Editors

Questions and Answers About

VETERANS MEDICAL SERVICE

M. L. McCLUNG, M.D.

Chief Medical Officer, VA Regional Office

INDIANAPOLIS

The Designated Examiners' Bulletin is presented, not for the purpose of telling you how to practice medicine, but to assist you in carrying out the functions of a designated examiner, in the best interests of yourself and the Veterans Administration. In the bulletin we will try to set out some general rules which, if followed, will simplify your work and ours and aid in rendering better service to the eligible veteran.

You have been advised from many quarters the procedure to follow in rendering this service, and at times the professional-patient relationships have been taxed by what would at first appear to be complicated detail. In an effort to assist you the problems will be presented in question and answer form, and it is hoped the answers will aid you in arriving at a solution to your case problem.

(1) WHAT TYPES OF SERVICE ARE OFFERED THROUGH THE FACILITIES OF THE DESIGNATED EXAMINERS?

There are, in general, three types of service to be rendered. The first is the examination for compensation purposes. In this examination you are to cover the service disability only, using VA Form Ind. 22, which is included with each authority issued to you. It will be noted at the top of this form, as well as on the authority, that the disability of service origin is set out after the word "specialty." In setting forth your findings you should paint a word picture clear enough so that the members of the rating board can visualize the findings present at the time you make the examination. The diagnosis should be set down as a separate entity and, if there is more than one, the most important should appear first.

The examination should be concluded by answering the two questions at the bottom of the page. All examinations should be signed. More will be said of the content of these examinations later.

The second examination you will be called upon to do is the examination for out-patient treatment. In this examination the Form A-106 will be included with your authority. The two most important parts of this examination are the diagnosis and treatment recommendations. The recommendations should show the type of treatment recommended, as: superficial x-ray; physical therapy (diathermy); local irrigations, etc., and the frequency, as: once weekly, three times weekly, daily, or two treatments a month. It is upon your recommendations that treatment will be rendered, and before we can authorize them they must be explicit as to type and frequency.

The third type of examination you will be authorized to do is the completion of the Form P-10, application for hospital treatment or Domiciliary care.

This authority will come from one of two sources: The Veterans Administration Local Contact Representative or the Veterans Administration Regional Office. The medical certificate on the back of this form can be briefly done, but should be of sufficient detail to express the need of the veteran for hospital or domiciliary care. The more clear-cut the findings in such a case being considered, the less detail is required. A hernia is a hernia and will require hospital care for repair. Arthritis is less clear-cut and the examination must be more complete in order to express the need. History and symptoms are important in a duodenal ulcer, as well as the patient's response to alkalies and medication. A distinction must always be made between handling the case on an out-patient basis or a definite need for hospital treatment, in order to get it under control.

More will be said of the individual examination later.

(2) HOW CAN YOU BE ASSURED OF BEING PAID FOR YOUR PROFESSIONAL SERVICES BY THE VETERANS ADMINISTRATION?

This is assured by obtaining prior authority from the Veterans Administration. Any case that is referred to you from the Veterans Administration Regional Office is accompanied by a written prior authority. It will be vouchered and paid when you have returned the completed examination.

(3) WHAT IS THE PROCEDURE WHEN THE VETERAN COMES TO YOU FOR THE TREATMENT OF A SERVICE CONNECTED DISABILITY THAT IS MEDICALLY EMERGENT?

This is the time when prior authority is essential. It is obtained in emergencies by your calling the Veterans Administration Regional Office, and telling them what you desire to do for the veteran. Such authority is given conditionally and depends for its validity only on the fact that the veteran is service connected for the condition for which you intend to render treatment. The phone call may be placed and the charges for the call reversed. The Veterans Administration will accept the call without question. If emergency treatment is ren-

dered after 4:30 p.m. Monday through Friday, or Saturday, Sunday, or a holiday, and reported within seventy-two hours after the beginning of the first working day, prior authority will be granted. The condition must be emergent and service connected.

(4) WHAT INFORMATION MUST I BE ABLE TO GIVE TO THE VETERANS ADMINISTRATION TO GET THIS PRIOR AUTHORITY?

The name and address of the veteran; his rank and organization; dates of enlistment and discharge; whether or not he is drawing compensation; in addition, the number of professional visits you will make a day or the number of office visits you desire the veteran to make, and any special medication or diagnostic procedures or treatments you will prescribe.

(5) WHERE WILL I OBTAIN THE DATES OF ENLISTMENT, DISCHARGE, ETC?

From the veteran's discharge papers.

(6) SUPPOSE THE VETERAN REQUIRES LOCAL HOSPITALIZATION?

Again it is imperative that you call for prior authority. This will be given conditionally, depending on whether or not the veteran is to be treated for a service connected disability. In requesting hospitalization be prepared to give the name and address of the hospital, the type of room available (ward, semi-private or private), the number of visits you will make per day, need for special diagnostic studies, transfusions, smears, blood counts, x-rays, etc., should be included in the request, or if hospital care is required as an emergency after the close of business (4:30 p.m.) Monday through Friday, or on a Saturday, Sunday or holiday, authority will be granted if requested within seventy-two hours from 8:00 a.m. of the first working day following the patient's admission. If requests for emergency hospitalization of service connected cases are referred to the Indianapolis regional office, medical division, only you may be sure of a properly executed authority.

(7) WHAT HAPPENS IF THE NEED FOR A SPECIAL PROCEDURE DEVELOPS A FEW DAYS AFTER THE VETERAN HAS BEEN HOSPITALIZED?

If it is to be paid for by the Veterans Administration prior authority must be obtained for it by phone, as described above. The Veterans Administration will accept the reverse charges.

(8) WHAT IS MEANT BY "SERVICE CONNECTION?"

When the term "service connection" is used it implies that the disability in question has been rated by the Adjudication Service of the Veterans Administration as service connected. It will be noted that a disability might be service incurred but not service connected, because the veteran has never filed a claim for service connection (Form 526) with the Veterans Administration.

(9) SUPPOSE THE VETERAN HAS SERVICE CONNECTION FOR PULMONARY TUBERCULOSIS AND NEEDS AN EMERGENCY OPERATION FOR APPENDICITIS. WILL THE VETERANS ADMINISTRATION "FOOT THE BILL?"

No. Hospitalization can only be authorized for service connected disabilities.

(10) MANY DESIGNATED EXAMINERS HAVE NOTED THE "LIBERALIZATION" OF THE LAWS AS SET FORTH IN A VETERANS ADMINISTRATION CIRCULAR NUMBER 215. THIS REFERS TO "PRESUMPTIVE" ELIGIBILITY FOR TREATMENT OR HOSPITALIZATION. JUST HOW DOES IT FIT INTO THIS PICTURE?

There are certain disabilities which, if they are diagnosed within two years after discharge, will be regarded as presumptively service incurred and will be recognized for treatment in emergencies as though they were already service connected. It will be seen that each disease entity is of a chronic nature and if it appears within two years could have been developing but "silent" prior to discharge. The designated examiner should carefully scrutinize the veteran's discharge for the discharge date before requesting emergency hospitalization.

(11) A VETERAN PRESENTS HIMSELF WITH A CASE OF CHRONIC RECURRENT MALARIA. WHAT ACTION SHOULD THE DESIGNATED EXAMINER TAKE?

If it is emergent he should proceed as previously instructed—obtain prior authority to treat. If the case is not emergent he should be sent to a Veterans Administration Contact Officer or a Service Officer of the V. F. W., the American Legion, D. A. V., or American Red Cross, to file a Form 2827, application for out-patient treatment. When such an application is received by the Veterans Administration for either a service connected condition or one that may be regarded as presumptively service incurred he will be referred to a local, designated examiner on prior authority for an out-patient examination and treatment recommendations. When the treatment recommendations are received he will be referred to the same examiner for the treatment prescribed.

(12) WHEN A DESIGNATED EXAMINER IS CALLED BY THE FAMILY TO A VETERAN'S HOME AND IT IS FOUND THAT HE IS ILL, IN BED AND IN NEED OF HOSPITAL CARE, WHAT SHOULD BE DONE?

In such a case, unless the veteran is so ill that he cannot be safely moved, a telephone request should be placed with the nearest Veterans Administration hospital for a bed. Your call will be accepted, charges reversed. All you need is to tell the hospital your diagnosis and how the veteran can travel. The proper authority will be given verbally and conditionally. If travel is by ambulance the need for such travel must be shown on arrival at the hospital, and also that the veteran is ill enough to be admitted as an emergency. A P-10

need not be made on a case requiring emergency hospital care. If the case is emergent and the veteran cannot be moved safely to the nearest Veterans Administration hospital and the condition is service connected, then a bed at a local hospital can be requested as instructed above. If the condition is not service connected and the veteran is too ill to move to the nearest Veterans Administration hospital, then no part of the expense can be borne by the Veterans Administration.

(13) WHAT RECOURSE, IF ANY, HAS THE VETERAN OR THE DOCTOR IF A VETERAN IS HOSPITALIZED LOCALLY AS AN EMERGENCY AND LATER IT IS BELIEVED THAT THE DISABILITY FOR WHICH HE WAS TREATED IS SERVICE CONNECTED?

This brings up the claim for unauthorized medical treatment which the veteran, the hospital or the doctor may file with the Veterans Administration, if all four of the following conditions are met:

A. The condition treated must have been service connected or the veteran was a trainee under Public Law 16 at the time treatment was rendered.
B. The treatment must have been rendered in a definite medical emergency.
C. Veterans Administration facilities must not have been readily available.
D. Any delay in treatment would have endangered the patient's life.

Unless all four of the above criteria can be shown the claim will be disallowed. Such a claim is usually instituted by the veteran, doctor or hospital by letter, requesting reimbursement for unauthorized medical treatment. The proper forms are forwarded if the disability treated is shown to be service connected by the veteran's case folder. If no service connection exists no further action can be taken. The necessity for such claims can be avoided by requesting prior authority in what appears to be a bona fide case.

(14) WHAT DOES THE RATING BOARD DESIRE IN AN EXAMINATION FOR COMPENSATION PURPOSES?

You will note first the condition to be covered by the examination. This is the one on which rating action or treatment action will be taken, and unless the examination is to be made on the blue form (2545) it will cover the single disability only.

First, you should give sufficient description to enable the Rating Board to adequately see the veteran's condition as it is now. There are a few points we will stress that should always be considered.

Eyes— Vision taken with the Snellen chart and recorded on the basis of twenty foot distance or fractions thereof, before and after correction by lens, giving diagnosis.

Ears—Hearing should be expressed as "ordinary conversation" heard in feet, distance right and left. Check at one, two, five, ten, fifteen and twenty feet.

Heart—Record area of heart dullness, murmurs, thrills, dyspnea, cyanosis, or edema. Record arteriosclerotic changes in peripheral circulation, blood pressure and pulse rate sitting, standing and three minutes after exercise.

Respiratory System—Give shape and measurements of chest, inspiration, expiration and at rest; differences in motility or contour; record physical signs in each lung separately upon percussion, palpation and auscultation; give areas and rib levels of infiltrations, cavitations or consolidation, adhesion or fluid levels; presence or history of cough or hemorrhage. In bronchial asthma, give history and frequency of true asthmatic attacks and medication necessary for relief of same.

Digestive System—Shape and contour of abdomen. Localized masses or tenderness; existence of constipation, nausea, vomiting, with frequency and measures that give relief; onset of distress; dietary indiscretions; in peptic ulcer cases, history and the length and frequency of incapacitating episodes.

Genito-Urinary System—Findings on palpation; distribution of pain; swellings, lymphadenopathy or tumors; frequency, pain, burning, and character of urine should always be shown.

Skeletal System—Describe crepitus, swellings, atrophy, limitation of motion in degrees of deformity, shortening or ankylosis. The joints should be considered as individual entities and described with the above points in mind. The feet should show the degree of flatness or weakness. Are they painful? Does he have bunions? Are they inflamed or painful? Where is weight-bearing line? Is there bowing of Tendo-Achilles?

Skin—Describe the lesions, vesicular, macular, papular, pustular, and give the approximate size of the areas involved. The areas should be named. If on hands, face, or neck, describe disfigurement.

Gunshot Wound Scars—Give the size and location of the scar. Was there loss of muscle substance? Is the scar painful? Does it produce disfigurement or deformity? Does it interfere with normal functions? Is it affected by heat or cold? Is circulation impaired? Give name of muscles, if damaged.

(15) ARE FAMILIES OF VETERANS ENTITLED TO MEDICAL TREATMENT BY THE VETERANS ADMINISTRATION?

No. Treatment is confined to honorably discharged veterans only.

(16) TO WHAT SERVICE IS THE STUDENT VETERAN ENTITLED?

A distinction must be made here between those in training under Public Law 16 and those under

Public Law 346. The veteran in training under Public Law 16 is entitled to any medical service necessary to keep him in training and to avoid interruption. Local student health services at the school are able to care for minor conditions, but the patient may be referred to a designated medical examiner for major medical care. The examiner should be assured that the Veterans Administration Regional Office has been contacted and authority secured before rendering the service. If there is a doubt, the doctor should call the Veterans Administration for authority.

Those under Public Law 346 are not entitled to designated medical services for conditions other than those that are rated as service connected. If you are practicing in a college or university town and the veteran is not sure whether he is in training under Public Law 16 or Public Law 346, before proceeding with treatment, call the office of the Vocational Advisor at the school or college for this information. Remember, the V.A. can pay under Public Law 16, but cannot pay if the training is under Public Law 346 and the veteran is not service connected for the condition.

(17) BY WHOM MAY AN AUTHORITY BE ISSUED?

An authority may be issued by the Chief Medical Officer or his designate at a Regional Office, by the Officer of the Day of a Veterans Hospital. Authority for a P-10 examination can be given by Veterans Administration Contact Representatives from their offices in South Bend, Muncie, Evansville, Ft. Wayne, Lafayette and Terre Haute.

(18) IS PRENATAL, OBSTETRICAL OR POSTNATAL CARE PROVIDED FOR FEMALE VETERANS?

No. Female veterans discharged from service for pregnancy should apply to the military for their obstetrical service.

(19) WHAT ARRANGEMENTS ARE MADE FOR HOSPITALIZING A WOMAN VETERAN?

A female veteran may be hospitalized in a Veterans Administration Hospital that has beds for women. A female veteran may also be hospitalized in a contract or private hospital if the condition is medically emergent. If the condition is non-emergent and not service connected, the female veteran's name will be placed on the waiting list and a bed provided at a Veterans Hospital.

(20) WHAT PROCEDURE IS USED IN SECURING HOSPITALIZATION FOR A MENTALLY INCOMPETENT VETERAN?

If you are called to see a veteran who is a mental case and needs hospital treatment as an emergency, you should first ascertain if the veteran will accept the hospital treatment. If he consents, you should place a call with the nearest mental hospital and request a bed. If, however, the veteran refuses to be hospitalized, the Veterans Administration can take no action until the veteran has been committed by the courts. If the patient is violent and dangerous to himself or others, then the matter must be referred to the local police authorities for his safety until commitment proceedings can be consummated. Remember that the Veterans Administration has no police powers and cannot interfere until the patient has been committed. The Veterans Administration does not enter into the securing of commitments. This is a problem for the immediate family of the veteran.

(21) WHAT ARE THE TERRITORIES SERVED BY THE SEVERAL VETERANS ADMINISTRATION HOSPITALS?

When hospital treatment is desired as an emergency for veterans residing in: Lake, Porter, La Porte, Starke, Marshall, St. Joseph or Elkhart counties, the Clinical Director of the hospital at Hines, Illinois, should be called.

When hospital treatment is desired as an emergency for veterans residing in: Floyd, Harrison, Crawford, Perry, Orange, Washington, Clark, Jefferson, and Scott counties, the call should be directed to the Clinical Director of the VA Hospital at Louisville (Nichols General VA Hospital).

When hospital treatment is desired as an emergency for veterans residing in: Gibson, Posey, Vanderburgh, Warrick, Spencer counties, the call should be directed to the V.A. Hospital, Marion, Illinois, for the attention of the Clinical Director.

Residents of Wayne County are directed for emergency hospital treatment to the hospital at Dayton, Ohio.

Calls should be placed for the Clinical Director on working days, and for the Officer of the Day after hours and on Saturday, Sunday and holidays.

When a call is placed, give the name and address of the veteran, your diagnosis, and how the veteran can travel. The last is very important.

For counties other than those listed above in the State of Indiana, calls for emergency hospitalization may be directed to the Veterans Administration Hospital, 2601 Cold Spring Road, Indianapolis, Indiana, telephone Talbot 1521, Extension 55, during working hours, and Extension 50 after 4:30 on Saturday, Sunday and holidays; or The Veterans Administration Billings Hospital, Fort Benjamin Harrison, Indiana, Cherry 0500. Both of the above are general medical hospitals.

For all neuropsychiatric cases in the State of Indiana, calls for emergency hospitalization should be directed to Doctor Post, Clinical Director, Veterans Administration Hospital, Marion, Indiana. This hospital should be called only if the veteran is willing to accept hospital treatment; otherwise see paragraph 20 of the V.A. Medical Bulletin No. 1.

DIRECTOR OF VETERANS ADMINISTRATION MEDICAL ACTIVITIES

REGIONAL OFFICE

Mr. M. D. Cummins, Manager.
Dr. M. L. McClung, Chief Medical Officer, Regional Office.
Telephone—Talbot 1521, Extension 47.

Dr. Donald R. Adams, Asst. Chief Medical Officer.

Telephone—Talbot 1521, Extension 80.

(Call this number 8:00 a. m. to 4:30 p. m. if requesting authority to treat a service connected case as an emergency.)

We solicit additional questions from the Designated Examiners concerning their problems. You may be assured that your questions will be answered by return post and the questions will also be used as a basis for future Medical Bulletins. Address question letters to:

The Assistant Chief Medical Officer,
Veterans Administration Regional Office,
36 South Pennsylvania Street,
Indianapolis 4, Indiana.

(22) SUPPOSE I AM SENT AN AUTHORITY TO EXAMINE AND TREAT A CASE OF A SERVICE CONNECTED DISEASE OR INJURY AND ON EXAMINATION FIND HE WILL REQUIRE THE ADMINISTRATION OF MEDICINES AT HOME. AM I EXPECTED TO FURNISH THESE MEDICINES OUT OF MY $3.00 EXAMINATION FEE?

No. You may write a prescription on your own prescription blank for the medicines desired. Be sure to show the following:

The name and address of the veteran.

The date the prescription is written.

It must be signed by you. Typed or written on the front or back of the prescription must appear the following words: "I am authorized to treat and prescribe for the above-named V.A. patient."

Send the veteran, with this prescription, to one of the V.A. participating pharmacies and they will fill the prescription and bill the V.A. for cost of same.

NOTICE

WHEN AUTHORITY IS GIVEN FOR YOU TO PERFORM AN OPERATION AS LISTED IN THE SCHEDULE OF FEES, THE FEE WILL INCLUDE 14 DAYS POST-OPERATIVE VISITS.

This limitation was omitted when the schedule was printed. Therefore, for 14 days no additional payments will be made for hospital or home visits beginning with the date of the operation.

CONSIDER PHYSICAL MEDICINE SEPARATE MEDICAL SPECIALTY

Physical medicine has progressed to such a degree that it must be considered a separate and distinct medical specialty, according to an article in the November 9 issue of *The Journal of the American Medical Association.*

The author, George Morris Piersol, M.D., of Philadelphia, urges the practicing physician to avail himself of the "experience and advice" of the physiatrist in the same way he avails himself of the services of the roentgenologist, the gastroenterologist, the surgeon and other qualified specialists. The physiatrist is a new term applied to physicians who are qualified to employ the physical and other effective properties of light, heat, cold, water, electricity, massage, manipulation, exercise and mechanical devices for physical and occupational therapy in the diagnosis and treatment of disease.

"Closer cooperation and better understanding between the general practitioner and the specialist in physical medicine must be fostered," Dr. Piersol says, "if the large number of patients who need physical therapy are to receive the most effective treatment.

Dr. Piersol, who is from the Center for Instruction and Research in Physical Medicine at the University of Pennsylvania, believes that the public is "acutely interested in the worldwide problem" of rehabilitation, which has been defined as the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable.

"Thousands of veterans returning to various communities are suffering from, and many will continue for years to suffer from, injuries and disabilities which require for their proper management physical and occupational therapy. . . . Those veterans who, during their service experience, have learned the value of physical therapy will be justified in insisting on a continuation of such treatment from their family physician.

"It is a mistake to think that problems of reeducation or reconditioning are limited to disabilities incurred as the result of war. In a great nation such as this, in which the bulk of the population comprises workers engaged in all forms of activity, the annual toll of industrial accidents far exceeds the number of the battle casualties of any war. When to this figure is added the appalling number of traffic accidents and the indeterminate number of nonindustrial accidents that occur in the home or elsewhere, the toll of civilian injuries that sooner or later require some form of reeducation reaches a staggering total. In 1940 industrial injuries alone were listed at 1,890,000. The loss of time as a result of these injuries, if deaths and permanent disabilities are included, is estimated at 233,840,000 working days, the equivalent of the full time work of 780,000 workers."

Specialists in the field point out that rehabilitation through physical therapy, occupational therapy, physical training and educational and recreational programs fills the gap between the customary end point of medical attention and the real necessities of many patients.

Dr. Piersol says that reluctance to employ physical forms of treatment is "in no small degree based on widespread misconceptions of what is involved in this type of therapy. It is believed that effective physical therapy requires the use of complicated and expensive apparatus. The experience of a department of physical medicine in a general hospital shows that the contrary is true.

"As is the case with all therapeutic agents that bring about definite physiologic reactions, the procedures employed in physical medicine are capable of doing harm as well as good. Not only is it essential to select the proper procedure or combination of procedures, but their dosage must be regulated in regard to intensity, duration and frequency. Disappointing and at times harmful results have frequently been recorded because of lack of attention to or ignorance of these details."

On the basis of a survey of the prescriptions which referring physicians sent to a department of physical medicine, Dr. Piersol found that 57 per cent of the conditions were represented by chronic arthritis, neuromuscular pains of undiagnosed origin, strains and fractures.

MUTUAL MEDICAL INSURANCE, INC.

Initial gains and long-range aspects of the Indiana Doctors' Plan for surgical and medical insurance were presented before a meeting of the membership of the Indiana State Medical Association in convention assembled on October 30 by Dr. Walter U. Kennedy, who issued an earnest challenge to his profession to help solve the problem of health care for low-income groups.

Dr. Kennedy, President of Mutual Medical Insurance, Inc., under which name the Doctors' Plan operates in this state, was enthusiastic in his report on progress of the new enterprise since its inception on September 1, 1946.

Mutual Medical Insurance, Inc., was organized after several years of study by committees of the State Medical Association in an effort to develop a sound and practical plan for solving the problem of providing medical care for the working people of Indiana. Several hundred Indiana physicians subscribed to the operating and guaranty funds of the organization in order that it might be adequately financed from the beginning.

The Doctors' Plan operates as a companion plan to the Blue Cross Hospital Service Plan and is being offered to all Blue Cross groups. Its officers have contracted with the Blue Cross Plan for the handling of membership acquisition, collection of membership fees, and other internal office procedures.

Throughout September, he reported, the General Motors Corporation in an unprecedented action opened their plants for mass enrollment, and Blue Cross (handling the surgical and medical enrollment jointly with hospital service enrollment) threw its entire forces into an intensified campaign, almost entirely in large factories. Enrolled in the first two months of operation: sixty thousand persons. Potential membership visualized: more than one million.



First benefit check of new Indiana doctor-sponsored prepayment surgical and medical plan went to Peter Korellis, left, of Hammond, to pay surgical fees for his son, George, center, who underwent a major operation at St. Margaret hospital, Hammond. Clark E. Mullen, Blue Cross Hospital Service representative, who also is handling enrollment for the Doctors' Plan in Lake County, presented the check.

The Enrollment requirements of this Plan are identical to that of the Blue Cross Plan and will be offered to employed groups of five or more people through their places of employment. It is pointed out that the Doctors' Plan is an indemnity plan and not a service plan. Whereas the Blue Cross Plan pays for all services rendered in the hospital, as provided in its Certificate of Membership, the Doctors' Plan has developed a schedule of specific sums to be allowed toward the payment of the Doctors' bills when the patient is hospitalized.

After a doctor has rendered service to a member, he will fill out a claim form furnished to him and forward it to Mutual Medical Insurance, Inc., with offices in the Test Building, Indianapolis. The check will then be drawn jointly to the doctor and the member and mailed to the member. In this way the member will have his check bearing his name and the doctor's name, and he can make settlement with the doctor for service rendered to him.

Maternity care is covered either in the hospital or in the home. Surgical benefits are provided for operations performed in hospitals and, in addition, payments are made toward fractures, dislocations, and tonsillectomies in the home or doctor's office. In hospitalized cases where surgical and obstetrical services are not involved, the Plan provides three dollars a day for each day the doctor calls upon the member, after the third day, for twenty-one days in each Certificate year.

Monthly membership fees for combined hospital, surgical, and medical care are as follows:

STANDARD HOSPITAL ACCOMMODATIONS

Single Certificate	$2.00
Family Certificate	$4.75

WARD HOSPITAL ACCOMMODATIONS

Single Certificate	$1.80
Family Certificate	$4.25

The Doctors' Plan, together with the Blue Cross Hospital Service Plan, provides a comprehensive health care program. Membership in these companion Plans eliminates the financial problems that accompany unexpected illness which requires surgical and hospital care. By permitting the deduction of a nominal membership fee from their paychecks each month, employed people are able to budget for the unpredictable and immeasurable costs of illness of themselves and their families.

Medical Panorama by the Associate Editor

CONNECTICUT STATE MEDICAL SOCIETY, acting in joint conference with the Connecticut Pharmaceutical Association, reapproved a resolution adopted in 1941 recommending that physicians use prescription forms omitting a pharmacist's name.

———SIM———

GEORGIA appeals to doctors and auxiliary members and all citizens "to assist in every way possible to enroll 500 qualified students for the fall classes in Georgia schools of nursing." The convention theme of the Georgia nurses, meeting at Macon, was: "Now Is The Time for Forward Motion — Progress Will Then Be Inevitable." Hm-m-m-m!

———SIM———

LOUISIANA STATE MEDICAL SOCIETY announces the formation of their Louisiana Physicians Service, Inc. Designed to present a prepayment plan to care for the average and low income groups needing medical care, this voluntary plan affords a schedule of benefits for participating subscribers and physicians commensurate with catastrophic hazards involved, without limitations of red-tape restrictions.

———SIM———

CALIFORNIA is viewing with some apprehension the workings of their new cash sickness indemnity law. The physician is again "put on the spot," in his patient relationship, in being required to certify the sickness of the applicant and to estimate the period of disability. Rhode Island's experience, with a 1 per cent tax rate on wages, does not appear too rosy in a review by the Research Council for Economic Security.

———SIM———

OHIO STATE MEDICAL JOURNAL asks you "What are you going to do about it?" The question involves the dilemma which finds labor, in both branches, supporting the proponents and philosophy of regimented medicine, as opposed to the general acceptance of the majority of the people for free enterprise in medicine and all other American activities. Accepting the right of labor groups to formulate policies and to support them they also reserve this right to all interested groups to oppose them. If you are concerned about your own interests they suggest you get busy, contact your representatives, learn their attitudes, and *get busy.*

NATIONAL SOCIETY FOR MEDICAL RESEARCH, recently organized under sponsorship of the Association of American Colleges, with cooperation of 101 national scientific organizations, has as its purpose the advancement of research in medicine, biology, pharmacy, dentistry, and veterinary medicine. It will also analyze and expose the propaganda of groups which object to the use of animals in experiments.

———SIM———

THE CHAMBER OF COMMERCE of the United States has endorsed research on animals for the development of life-saving medical knowledge. Representative of a poll of over a million business men, 2,424 organizations were in favor thereof; only 18 against.

———SIM———

VIRGINIA offers a plan to correct the shortage of nurses by offering two courses in training. One, a training period of two years, with a substantial reduction in didactic work; and the other, a post-graduate course for training in special lines.

———SIM———

MINNESOTA MEDICINE offers the thought that "the Medical profession, as a whole, has been rather thoughtless in making provisions for aiding its needy members and their families." It suggests that "every large county society should establish a foundation to provide assistance to members in case of need." State societies should "do likewise to provide for equally needy members in rural districts."

———SIM———

THE WISCONSIN MEDICAL JOURNAL again scores a "first" in including within its pages a progressive idea of presenting, in newspaper format style, an informative section devoted to the problems of medicine in their socio-economic aspects. There are a multitude of journals in this country, faithful in their presentations of scientific material. Wisconsin does this, and more. Their annual "Blue Book" is a bible of information and guidance to their professional members, and the pages of their monthly Journal pay so much attention to the problems affecting every-day medicine that one could well wish that *all* members of the medical profession would read and profit from it.

What's Going On In Indiana by the Executive Secretary

New Officers Elected. Dr. Cleon A. Nafe, of Indianapolis, was elected president-elect of the association by the House of Delegates on October 31. He will become president January 1, 1948, succeeding Dr. Floyd T. Romberger, of Lafayette, who succeeds Dr. Jesse T. Ferrell, of Fortville, as president, this coming January 1. Doctor Nafe was elected without contest, as were the following, all re-elected: Dr. E. M. Shanklin, of Hammond, Editor of THE JOURNAL; Dr. A. F. Weyerbacher, of Indianapolis, treasurer; Dr. H. G. Hamer, of Indianapolis, and Dr. A. S. Giordano, of South Bend, delegates to the A.M.A. House of Delegates; and Dr. Karl R. Ruddell, of Indianapolis, and Dr. George Collett, of Crawfordsville, alternate delegates. As the Second District had failed to elect a councilor at its annual meeting last summer, the House of Delegates was compelled to act, and Dr. James H. Crowder, of Sullivan, the acting councilor, was named. The Council elected Dr. Lall Montgomery, of Muncie, and Dr. Pierce MacKenzie, of Evansville, to the Editorial Board of THE JOURNAL, succeeding Dr. M. A. Austin, of Anderson, and Dr. Minor Miller, of Evansville, respectively, who had served two terms on the board and were ineligible to re-election.

——ISMA——

Vote for Hospital. The Hancock County Medical Society, which for some years has advocated the erection of a hospital at Greenfield, expects to see its dream come true within the near future. On November 5 the voters expressed approval of the proposed building, 8,290 to 805. The way is now cleared for the county council to appropriate up to $300,000 for hospital construction. Application will be made for one-third of the project's cost from funds to be made available for hospital facilities under terms of the Hill-Burton bill enacted by the 79th Congress.

Veterans Medical Care. Physicians who are participating in the Indiana State Medical Association—Veterans Administration program for treatment of servicemen should read carefully all the bulletins sent them by the VA regional office in Indianapolis. By so doing they will save themselves time and trouble. These bulletins, with amplifications, will be published in THE JOURNAL. The first one appears elsewhere in this issue. This arrangement whereby private physicians treat veterans is an elaborate undertaking, and because the diagnoses often determines the amount of compensation paid a former service man, certain "red tape" is unavoidable. A safe rule to follow is to get authorization for everything you do in the way of treatment. A telephone call to the VA (you may reverse the charges) or a note to the regional office asking for this authorization will prevent disputes over fees and loss of money for doing unauthorized work. On November 10 approximately 850 doctors had signed as examiners. Indiana has an estimated 432,000 veterans, so the enormity of this medical care program is clearly seen.

——ISMA——

French Lick Next Year. The management of the French Lick Springs Hotel, where the 1947 annual state meeting will be held, through action of the House of Delegates, has promised to "hold the line" on rates unless prices generally skyrocket. Hotels in West Baden will be needed, too, to take care of the anticipated attendance. Efforts will be made to work out an arrangement whereby persons sleeping in West Baden may take their meals at the French Lick hotel. If this can be done, it will not be so inconvenient for those who are registered elsewhere. The dates will be selected by the executive committee. They must be chosen so as not to conflict with dates of other state medical associations and, of course, not to conflict with other conventions booked at the hotel.

Secretaries' Conference on January 12

The annual Secretaries' Conference will be held in the Riley Room of the Claypool Hotel, Indianapolis, on the afternoon and evening of Sunday, January 12, 1947.

The Committee is preparing an attractive program which will feature several out-of-state speakers. Beginning at 1:30 p.m., subjects of vital interest will be discussed. Dinner will be served at 6 o'clock, after which the principal address of the conference will be heard.

The meeting is open to all members of the Association, as well as county medical society officers.

Society Reports

INDIANA STATE MEDICAL ASSOCIATION

COUNCIL

(Indianapolis Session, 1946)

FIRST MEETING

The first meeting of the Council was held in the Kneipe Room of the Murat Temple, at 12:30 p. m., Tuesday, October 29, 1946, the chairman, Dr. A. M. Mitchell, of Terre Haute, presiding.

Roll call showed the following members present:

Councilors:

First District—I. C. Barclay, Evansville
Second District—J. H. Crowder, Sullivan
Third District—A. P. Hauss, New Albany
Fourth District—Charles F. Overpeck, Greensburg
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Tenth District—William H. Howard, Hammond
Eleventh District—C. S. Black, Warren
Twelfth District—A. Jerome Sparks, Fort Wayne
Thirteenth District—Alfred Ellison, South Bend

Officers:

J. E. Ferrell, Fortville, president
Floyd T. Romberger, Lafayette, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
E. M. Shanklin, Hammond, editor of THE JOURNAL
N. K. Forster, Hammond, associate editor of THE JOURNAL

Members of Executive Committee:

Cleon A. Nafe, Indianapolis, chairman
C. H. McCaskey, Indianapolis
Albert Stump, Indianapolis, attorney
Thomas A. Hendricks, executive secretary emeritus
Ray E. Smith, executive secretary

Chairman of A.M.A. Board of Trustees:

R. L. Sensenich, South Bend

Delegates to the A.M.A.:

H. G. Hamer, Indianapolis
A. S. Giordano, South Bend
Don F. Cameron, Fort Wayne
F. S. Crockett, Lafayette

Alternate delegates to the A.M.A.:

Karl R. Ruddell, Indianapolis
George A. Collett, Crawfordsville
Norman M. Beatty, Indianapolis

General Arrangements Chairman:

Gordon W. Batman, Indianapolis

Legislative Committee:

Norman M. Beatty, Indianapolis } co-chairmen
J. William Wright, Indianapolis }

State Board of Health:

L. E. Burney, Indianapolis, director
George V. Cring, Portland

Upon the motion of Dr. Sparks, seconded by Dr. Clark, the minutes of the July 21 Council meeting, held in Indianapolis, were approved as printed in the September, 1946, issue of THE JOURNAL.

No additions to or comments were made on the formal councilor reports which were printed in the October JOURNAL.

District meetings were reported scheduled as follows:

Third District—New Albany, June 4, 1947
Thirteenth District—Elkhart, November 13, 1946

REPORT OF TREASURER

DR. A. F. WEYERBACHER: This report was prepared for the Executive Committee and I was instructed to read it here today:

"The Executive Committee has directed me to give an estimated account of our anticipated income for 1947. The Budget Committee does not meet until after the first of the year. However, based upon past experience we can come to some general conclusions. We can count upon a membership of approximately 3400, of which probably less than 200 will be in service and therefore non-paying members. We carry at present 155 honorary members. Basing our receipts on a paying membership of about 3,000 members at $10.00 per member, we will have $30,000 income from memberships. From exhibit rent we may expect at least $5500.00. If the meeting should be held here it would be considerably more. If it is held somewhere else, it won't be over $5500.00. Other receipts are negligible, except the $800.00 interest which is a standard receipt from bond holdings.

"I also have a report from the business office of our JOURNAL. JOURNAL receipts as of September 30, 1946, totaled $25,730.56, and our receipts to date for October total $2,360.64, making a total of $28,091.20. In addition, I believe we are safe in assuming that our November and December receipts will total at least $4,000.00, and, basing our Cooperative Bureau rebate on the $2800.00 received last year, we should have at least a $3,000 rebate for 1946, making an estimated total of $35,091.20 for 1946, as compared with our total receipts of $29,326.00 for 1945. Of the $35,091.20, about $28,253.00 will comprise our advertising and paid subscription receipts, and $6,838.00 represents the $2.00 per member allowance from the association dues.

"According to present indications there is no reason to suppose that our receipts for 1947 will not be as good, and they may be higher. Although only a few renewal contracts have been received to date, Mr. Jackson of the Cooperative Medical Advertising Bureau has reported that the prospects are good for 1947. However, to offset that, there has been a decided increase in the cost of paper and printing, and it continues to go up, so it is

impossible to estimate the cost of publishing THE JOURNAL next year. Certainly it will be considerably higher, perhaps 38 to 40 per cent more than it has been heretofore."

Now, in our optimism a year ago we thought we could knock off the $5.00 assessment and be in pretty good shape. We are, up to date, but we won't be after this year. It either means increasing our dues to $15.00 instead of $10.00, or put back the assessment we had before. That's up to you, whichever way you want to do, or let it go; we can get by. Understand, we bought no additional bonds for our holdings in five years. We had a balance of a little over a thousand dollars last year, and we'll probably get by this next year, but certainly we ought to be able to pay as much for our membership here as a union man pays in his union. I don't believe, if it is brought up, that anybody would object seriously to an increase in the dues. However, I leave that for your consideration.

INCREASE IN DUES

On motion of Dr. Hauss, seconded by Dr. Clark, the Council went on record in favor of increasing the membership dues from $10.00 to $15.00 per year, and instructed the chairman of the Council to present this recommendation to the House of Delegates.

UNFINISHED BUSINESS

1. The chairman reported that in response to the resolution passed by the Council at the July meeting opposing the selling of space to medical quacks at the State Fair, a letter had been received from Lieutenant Governor Richard T. James stating that the State Fair Board would comply with the wishes of the Council.

2. *Report of the Committee for the Study of Nursing Service.* Dr. Clark presented a resolution that had been prepared by the Committee for the Study of Nursing Service at its meeting on Tuesday morning, October 29. Following discussion by Drs. Sparks, Clark, Beatty, Nafe, McCaskey, Hauss and Mr. Stump, the resolution was adopted on motion of Dr. Clark, seconded by Dr. Kennedy, and the recommendation was made that it be referred to the House of Delegates for its consideration.

Dr. Clark asked for the continuation of the Committee for the Study of Nursing Service. It was taken by consent that this committee be continued.

3. *Letter from Dr. Gatch.* It was moved by Dr. Clark, seconded by Dr. Crowder, that the following letter received from Dr. W. D. Gatch, in response to a letter from the Council, be included in the minutes:

"Dear Dr. Mitchell:

"Will you convey to the members of The Council my sincere thanks for their letter on my resignation as dean of the medical school?

"I have always held the belief that no medical school can thrive unless it has the support and good will of the physicians of the community in which it is located. I tried to conduct the medical school in a way which would meet the approval of the doctors of the state. I regret that I was not able to bring about too much needed changes in the state of the school. First, removal of the first year from Bloomington to Indianapolis, and, second, ending the domination of the Bloomington organization of the business administration of the school.

"I hope that The Council will do everything in its power to bring these changes about. I believe that the overwhelming majority of the physicians of the state favor them.

"Assuring you and the members of The Council of my high personal regard, I remain

"Sincerely yours,

W. D. GATCH, M.D."

NEW BUSINESS

1. *Auditing Committee report.* Upon the motion of Dr. Clark, seconded by Dr. Kennedy, the report of the Auditing Committee as published in the October JOURNAL, was accepted.

2. *Legislative program of State Board of Health.*

DR. L. E. BURNEY: I appreciate this opportunity to tell you of our proposed legislative program. One of the proposals would give to the Board authority to establish branch offices. We have discussed with you on previous occasions the establishment of five branch offices of the State Board of Health. The attorney general's office feels that the overall powers of the Board may not give to them the authority to establish such offices. So we are asking for an amendment to the basic act of the Board of Health. I would just like to read one sentence in this: "In granting the above authority to establish, operate and maintain branch offices of the State Board of Health, it is the legislative intent to authorize such establishment as a means of assisting, but in no sense limiting, the powers now possessed by all existing local health agencies, more particularly all city and county health officers and boards of health, in the performance of the duties now imposed upon them by law."

Then, as you know, the last General Assembly did pass an act which directed that the State Board of Health make a survey of all hospitals in the state, that they evaluate the sufficiency of such facilities and that they prepare a plan which would show where new facilities or additional facilities might be necessary. We were also given authority in that act to receive any grant-in-aid funds that might become available to assist in making the survey. Actually we have not received any outside funds—we have used existing funds to make the survey. You, I think, are familiar with the advisory hospital planning council which has been appointed to assist the State Board of Health. There are three physician-members that Dr. Forster recommended when he was president—Dr. Senese from Gary, Dr. Manion from Indianapolis, Dr. Combs from Terre Haute. We have also asked, and the governor has acquiesced, in appointing Dr. Crockett as an ex officio member of that group to assist us

in this planning. Although Congress has not appropriated any funds for construction, under the Hospital Construction Act, the act has been passed and it is assumed that Congress will appropriate the $75,000,000 at its next session, in which case Indiana's share would be $1,600,000. This is a comparatively small amount, and we have urged the hospitals not to count on that too much but to go ahead and raise the funds locally. But, these funds may become available, and in order that Indiana may accept them for use in assisting public and non-profit hospitals in their construction, we would have to have an amendment to our present act, which would give to the State Board of Health authority to receive and disburse any funds which might become available through the Hill-Burton bill.

Another proposed bill would establish a division of industrial hygiene in the State Board of Health. We have had such a division since 1938. Dr. Spolyar is the director of that division. The State Board has felt all along that in their general powers they have authority to establish any division that is necessary. However, there has been some question of responsibility between the Labor Department and the State Board of Health. We also believe that it is desirable that we have provision for such a division because many times industry has to expend large sums of money to correct a hazard, and we have been questioned several times as to the authority that we may have to insist upon this correction.

We have asked Mr. Stump to assist us in preparing the drafts of two laws which would strengthen our permissive legislation for full-time county health departments. In the 1945 General Assembly there was a law passed which permitted counties to establish full-time health departments. It permitted cities to establish full-time health departments. It did not permit a city and a county to join to form a city-county health department. So, we feel that that is one place that the law should be corrected. There is also no provision for boards of health in these counties. If a county now establishes a full-time health department, the county commissioners constitute the board of health. We believe a more representative board with stated authority is desirable. So we want to make provision for that in this new permissive legislation. I would like to emphasize the word "permissive" there; it isn't mandatory, it's permissive or enabling legislation. Another feature of the proposed act would state that not only may the county commissioners establish by resolution a full-time health department, but that a full-time county health department or multi-county health department might be established by popular referendum. We have a precedent for that in one of our hospital bills—1917. The Hancock County Medical Society, about six weeks or two months ago, used that in securing a petition signed in that county by which the county commissioners are mandated to make provisions for a vote on this proposition November 5. So we are suggesting the inclusion of this popular referendum idea with the hospital bill as a precedent, for the establishment of county health departments.

Another proposed bill would provide state assistance to counties in the establishment and maintenance of county health departments. We believe that the health of the people in the southern part of the state is of interest to those in the northern portion, that the state does have an interest in the health of all the counties, and although the main obligation is on the local community—they are the ones who should foot the major part of the bill—we do believe that the state does have some responsibility to assist these counties in establishing and maintaining full-time county health departments. For that reason we are proposing that the state appropriate a sum of money earmarked for local health departments, with the provision that the personnel employed in these local health departments receiving assistance shall meet the minimum standards of the State Board of Health. The appointment of the people is all on a local basis. I am sorry that we haven't been able to get this in the form to present to you here so that you would have time to look at it now or later, but it is a little more difficult job than we had thought originally, and as I said, Mr. Stump has been working on it, and we hope to have it within the next two weeks at least.

We are limited in the State Board of Health from paying any physician more than $6,000. We don't feel that we can attract competent doctors and retain competent doctors at $6,000.

DR. MITCHELL: Dr. Burney's report is merely informative.

DR. NORMAN M. BEATTY: May I suggest that the legislative committee chairmen have the opportunity of discussing this in detail at an executive session of the Council? (Taken by consent.)

3. *Signing of food handlers' certificates.*

DR. GEORGE V. CRING: I am here today to bring to your attention a practice to which the State Medical Council, or Executive Committee, once gave its approval, and to which I think you should soon give your disapproval and brand the type of practice unethical. I refer to the "Health Certificate for Food Handlers" and the manner in which it usually is made out. Each county society was directed to decide the charge to be made for signing the four papers, and I think it was generally decided that it be the fee charged for an office call.

Before a "Health Certificate for Food Handlers" is required I think the medical authority should study which diseases are food-borne, or are liable to spread because of the handler's duties, and how often and how thoroughly these handlers should be examined. These certificates were to expire one year from date of signing but were to become void if holder contracted a communicable disease in the

meantime. How was this later infection, affecting food handlers, to be found? Certainly not by the prevailing type of certificate-signing, nor through the inefficient case reporting.

The practice of the "graphite method," of physical examinations and the "sink test" laboratory procedures by the medical profession, do more than any other practice I know of to, first, misinform the public concerning true medical practice; second, to incite the resentment of employers and employees against this gangster-like charge of a fee without service; third, to give a false sense of security to the public (there have been definite epidemics from sources having these health certificates); and quite important, fourth, to break down the honor of the profession and to demonstrate the profession as a mercenary group, willing to sign anything for a nickel. One certificate goes to the food handler, one to his employer—written evidence of a fraud!

I have taken up the practice with many State Medical Society officers, members of former and present Councils and Executive Committees, physicians, members and Directors of the State Board of Health, and have no doubt been a vexation to many, but have at different times been told that the certificates would no longer be required.

However, in the recent instructions sent out telling the requirements for the licensing of hospitals this same certificate is given as necessary for food handlers of the hospital. Also I learn that, although the State Board of Health no longer requires them, the individual city or county health officers or employees are privileged to require them for food handlers, if they choose.

As this certificate is worded I believe there is no doctor, group of doctors, clinic or hospital that can sign this certificate, even after hours of examination, both physical and laboratory, with any satisfactory degree of honor or exactness. If signed, it is only as a free accommodation or for the fee obtained.

On investigation over the state I find that these certificates are filled out and signed for from nothing up to five dollars—in most instances for twenty-five, fifty, seventy-five cents, or one dollar, and in most cases of which I have learned there has been no examination made nor history taken. In some cases blood was taken for serology, or a chest x-ray was ordered.

(Here Dr. Cring discussed each question listed on the health certificate, calling attention to the fact that it included every infectious and contagious disease which an individual could have—either as a "disease" or as a "disease carrier" and it definitely listed "gonorrhea, syphilis, tuberculosis, typhoid, measles, and any other infectious or contagious disease." He discussed the difficulty of excluding these, especially typhoid and dysentery, and the inefficiency of the Wassermann or serology alone, and x-ray alone, in excluding all, especially some early and infectious states of syphilis and tuberculosis.)

Doctors, I think it is this type of practice that is causing the public to disrespect the profession and is promoting socialized medicine. I again say I know I am not telling you anything you do not already know but I do wish to call this problem to your attention and ask for action.

4. *Contact Committee of the Indiana State Medical Association with the Indiana State Department of Public Welfare.* Dr. Black, chairman of the State Welfare Advisory Board, asked that a contact committee from the Indiana State Medical Association be appointed, with authority to act with the State Department of Public Welfare, "to make better co-operation and to correct some abuses which are found in various parts of the state. . . . The State Department of Public Welfare would like to have a committee appointed by the state medical society as a contact committee that they could appeal to in these emergencies." Discussed by Drs. Romberger, Sparks, Mitchell and Nafe, Dr. Nafe saying that he felt the Medical Relief Committee, already in existence, should constitute this liaison committee and should be given authority to act with the State Department of Public Welfare.

On motion of Dr. Hauss, duly seconded, Dr. Black's report was referred to the Medical Relief Committee.

5. *Election of Editor of THE JOURNAL for 1947.* Upon the motion of Dr. Clark, seconded by Dr. Kennedy, Dr. E. M. Shanklin, of Hammond, was re-elected editor of THE JOURNAL for 1947.

6. *Election of Editorial Board members.* Upon motion of Dr. Ellison, seconded by Dr. Sparks, Dr. Pierce MacKenzie, of Evansville, and Dr. Lall Montgomery, of Muncie, were elected members of the Editorial Board, to serve for three years and to succeed Dr. Minor Miller, Evansville, and Dr. M. A. Austin, Anderson.

7. *Duties of Editorial Board.* On motion of Dr. Clark, duly seconded, the editor of THE JOURNAL is to supply the Council with a definition of the duties and responsibilities of the Editorial Board and report to the next meeting of the Council.

8. *Membership of Committee on Indiana Inter-Professional Health Council.* As this committee is limited to five members, the co-chairmen of the Legislative Committee of the state medical association are to decide which one of them shall be a member of this Inter-Professional Health Council.

DATE FOR MIDWINTER COUNCIL MEETING

The Council set Sunday, January 12, 1947, as the date for the midwinter meeting.

The Council adjourned, to go into executive session.

RAY E. SMITH,
Executive Secretary.

THE COUNCIL

(Indianapolis Session, 1946)

SECOND MEETING

The second meeting of the Council convened immediately following the adjournment of the House of Delegates, Thursday morning, October 31, 1946, with Dr. A. M. Mitchell, the chairman, presiding.

Roll call showed the following members present:

Councilors:

First District—I. C. Barclay, Evansville
Second District—J. H. Crowder, Sullivan
Third District—A. P. Hauss, New Albany
Fifth District—A. M. Mitchell, Terre Haute
Sixth District—W. U. Kennedy, New Castle
Seventh District—C. J. Clark, Indianapolis
Eighth District—E. H. Clauser, Muncie
Ninth District—Wemple Dodds, Crawfordsville
Eleventh District—C. S. Black, Warren
Thirteenth District—Alfred Ellison, South Bend

Officers:

J. E. Ferrell, Fortville, president
E. M. Shanklin, Hammond, editor of THE JOURNAL

Executive Committee:

Cleon A. Nafe, Indianapolis, chairman
Ray E. Smith, executive secretary

BADGES FOR PAST PRESIDENTS

DR. MITCHELL: It has been called to our attention that some of the past presidents of the association would like to have gold badges such as have been given to the presidents of the association at the annual session for the past ten or twelve years. About eight or nine past presidents did not receive these special badges. (Dr. Clark moved that each of the past presidents who have not received a gold badge be presented with one, this badge to carry their name and the year they served as president of the association. Motion seconded by Dr. Black, and passed.)

JOURNAL OFFICE

On motion of Dr. Ellison, seconded by Dr. Clark, the Council approved salary increases for THE JOURNAL office personnel, beginning November 1, 1946.

EXECUTIVE COMMITTEE MEMBERSHIP

Dr. Nafe presented his resignation as a member of the Executive Committee due to his election as president-elect of the association for 1947. Dr. Clark moved that Dr. Nafe continue in his position as chairman of the Executive Committee until January 1, 1947. This motion was seconded by Dr. Ellison and passed.

DR. FERRELL: I wish to thank all of you for your co-operation in making this grand meeting possible. You have stood behind me one hundred per cent. I thank you very much.

No further business appearing, the Council adjourned.

RAY E. SMITH,
Executive Secretary.

HOUSE OF DELEGATES

(Indianapolis Session, 1946)

FIRST MEETING

The first meeting of the House of Delegates of the 1946 session convened in the Murat Theater, Indianapolis, at 4:10 p. m., Tuesday, October 29, 1946, with the president, Dr. J. E. Ferrell, of Fortville, presiding.

On motion of Dr. M. B. Catlett, seconded by Dr. G. M. Nie, the attendance slips were accepted as the roll call. These slips showed the following members present:

County	*Delegates*
Adams	Ben Duke, Decatur
Allen	M. B. Catlett, Fort Wayne
	Maurice E. Glock, Fort Wayne
	Milton F. Popp, Fort Wayne
Bartholomew	J. E. Dudding, Hope
Benton	V. L. Turley, Fowler
Boone	Charles O. Weddle, Lebanon
Carroll	M. R. Adams, Flora
Cass	E. B. Jewell, Logansport
Clinton	F. A. Beardsley, Frankfort
Clay	J. F. Maurer, Brazil
Dearborn-Ohio	Charles N. Manley, Rising Sun
Decatur	H. S. McKee, Greensburg
Delaware-Blackford	Clay A. Ball, Muncie
	B. W. Stocking, Muncie
Dubois	S. L. McKinney, Huntingburg
Elkhart	Sam T. Miller, Elkhart
	A. C. Yoder, Goshen
Floyd	William H. Garner, New Albany
Fulton	A. E. Stinson, Rochester
Gibson	C. M. Clark, Oakland City
Grant	Russell W. Lavengood, Marion
Greene	King L. Hull, Bloomfield
Hancock	Joseph L. Allen, Greenfield
Harrison	William E. Amy, Corydon
Hendricks	O. T. Scamahorn, Pittsboro
Henry	Walter M. Stout, New Castle
Huntington	G. M. Nie, Huntington
Jasper-Newton	W. G. Pippenger, Brook
Jay	George V. Cring, Portland
Johnson	Oran A. Province, Franklin
Knox	C. L. Boyd, Vincennes
LaGrange	H. F. Flannigan, LaGrange
Lake	H. W. Eggers, Hammond
	C. M. Jones, Whiting
	P. Q. Row, Hammond
Madison	C. V. Rozelle, Anderson
	A. T. Jones, Pendleton
Marion	James F. Balch, Indianapolis
	Eugene F. Boggs, Indianapolis
	William M. Dugan, Indianapolis
	Bert E. Ellis, Indianapolis
	Harry L. Foreman, Indianapolis
	George J. Garceau, Indianapolis
	Roy A. Geider, Indianapolis
	Foster J. Hudson, Indianapolis
	L. T. Meiks, Indianapolis
	Cleon A. Nafe, Indianapolis
	Chester A. Stayton, Indianapolis
	C. F. Thompson, Indianapolis
Marshall	A. A. Thompson, Tyner
Miami	C. R. Herd, Peru
Montgomery	George A. Collett, Crawfordsville
Noble	J. R. Nash, Albion
Orange	C. E. Boyd, West Baden Springs
Owen-Monroe	William A. Karsell, Bloomington
Parke-Vermillion	F. G. Greene, Bloomingdale
	S. C. Darroch, Cayuga

County	*Delegates*
Pike	G. A. Dickinson, Petersburg
Porter	John R. Frank, Valparaiso
Posey	William B. Challman, Mt. Vernon
Pulaski	C. E. Linton, Medaryville
Putnam	G. D. Rhea, Greencastle
Randolph	Lowell W. Painter, Winchester
Ripley	R. Lee Smith, Osgood
Rush	Melvin H. Denny, Rushville
St. Joseph	F. R. N. Carter, South Bend
	A. S. Giordano, South Bend
Scott	Floyd S. Napper, Scottsburg
Shelby	W. D. Inlow, Shelbyville
Tippecanoe	Gordon A. Thomas, Lafayette
Tipton	S. M. Cotton, Goldsmith
Vanderburgh	C. W. Cullnane, Evansville
	C. C. Herzer, Evansville
	Minor Miller, Evansville
Vigo	Ernest O. Nay, Terre Haute
	M. C. Topping, Terre Haute
Wabash	O. G. Brubaker, North Manchester
Warrick	J. Guy Hoover, Boonville
Washington	Frederick K. Allen, Salem
Wayne-Union	Harry Plummer Ross, Richmond
	W. A. Thompson, Liberty
Wells	H. D. Caylor, Bluffton
Whitley	B. F. Pence, Columbia City

COUNCILORS

1st District—I. C. Barclay, Evansville
2nd District—J. H. Crowder, Sullivan
3rd District—A. P. Hauss, New Albany
6th District—W. U. Kennedy, New Castle
7th District—C. J. Clark, Indianapolis
8th District—E. H. Clauser, Muncie
9th District—W. Dodds, Crawfordsville
11th District—C. S. Black, Warren

PAST PRESIDENTS

W. R. Davidson, Evansville
E. M. Shanklin, Hammond
Charles N. Combs, Terre Haute
G. R. Daniels, Marion
C. E. Gillespie, Seymour
E. E. Padgett, Indianapolis
R. L. Sensenich, South Bend
Herman Baker, Evansville
E. M. VanBuskirk, Fort Wayne
K. R. Ruddell, Indianapolis
A. M. Mitchell, Terre Haute
M. A. Austin, Anderson
J. T. Oliphant, Farmersburg

OFFICERS

J. E. Ferrell, Fortville, president
Floyd T. Romberger, Lafayette, president-elect
A. F. Weyerbacher, Indianapolis, treasurer

DELEGATES TO A. M. A.

H. G. Hamer, Indianapolis
Don F. Cameron, Fort Wayne
N. M. Beatty, Indianapolis, alternate

Dr. William E. Amy, chairman of the Committee on Credentials, announced that a constitutional quorum of delegates was present, and the chairman declared the House open and ready for the transaction of business.

THE PRESIDENT: The By-Laws may be amended at any annual session by a *majority vote of all delegates present* at that session, after the amendment has laid on the table for one day. (Chapter XIV, Section 1, of By-Laws.)

The House of Delegates may amend any article of the Constitution by a *two-thirds vote of all delegates present at any annual session*, provided that such amendment shall have been presented in open meeting at the previous annual session and that it shall have been published twice during the year in THE JOURNAL of the Association. (Article XIV, Constitution.)

Any delegate who wishes to speak will please give his name and county so that the reporter may get it.

First of all we will rise in tribute to the memory of those who were members of the House of Delegates or who served the state association in an official capacity and who have died since the 1945 annual session. I will read their names:

LARUE D. CARTER, Indianapolis. Chairman of Committee on Scientific Work 1922, and member of that committee, 1926; member of Committee on Convention Arrangements 1924; member of Military Committee 1924; chairman of Committee on Mental Health 1934 through 1945; member of Liaison Committee with Indiana State Department of Public Welfare 1939 and 1940.

JOSEPH R. CROWDER, Sullivan. Secretary Sullivan County Medical Society 1926; member Committee on Credentials 1944 and 1945; delegate from Sullivan County, 1942 through 1944.

BURNHAM C. DALE, Marion. Secretary Grant County Medical Society 1922.

VANCE A. FUNK, Vincennes. Member of Committee on Scientific Exhibit 1917; Secretary Knox County Medical Society 1917.

HARRY KNOTT, Plymouth. Secretary Marshall County Medical Society 1917, 1919, 1920; vice-chairman Section on Anesthesia 1944, 1945; delegate from Marshall County 1942.

WENDELL D. LITTLE, Indianapolis. Chairman of Committee on Study of High School Athletics 1933 through 1944; chairman Committee on Physical Fitness 1946, until his death May 24; member of Committee on Physical Fitness 1945.

HERMAN G. MORGAN, Indianapolis. Member Committee on Convention Arrangements 1931; member Committee on Syphilis Control 1938; member Committee on Indiana Inter-Professional Health Council 1939 and 1940; delegate from Marion county 1934 through 1937.

GILES E. MOWRER, Jeffersonville. Secretary Clark County Medical Society 1922 through 1925; 1931 through 1938.

JOHN RAY NEWCOMB, Indianapolis. Member of Committee on Conservation of Vision and Hearing 1916; vice-chairman Eye, Ear, Nose and Throat Section 1917; chairman Eye, Ear, Nose and Throat Section 1918, 1919 and 1920; member Committee on Convention Arrangements 1924; member War Participation Committee 1943; vice-chairman War Participation Committee 1944 and 1945; member Cen-

tennial Celebration Committee 1945 and 1946; vice-chairman Postwar Committee 1946.

F. M. NICHOLS, Topeka. Secretary LaGrange County Medical Society, 1941.

GEORGE G. RICHARDSON, Marion. Vice-chairman, Medical Section 1921; chairman Medical Section 1922; chairman, Committee on Necrology 1923 through 1936.

WILL SHIMER, Indianapolis. Member of Committee on Pathology 1912 and 1913; member of Committee on Scientific Demonstrations 1914 and 1915; member of Committee on Scientific Exhibit 1916.

OSCAR H. STEWART, Orleans. Secretary, Orange County Medical Society 1920.

CHARLES C. STROUP, Bloomington. Secretary, Monroe County Medical Society 1914 through 1919.

O. H. SWANTUSCH, Angola. Secretary, Steuben County Medical Society 1914.

CASSELL C. TUCKER, Greencastle. Secretary, Putnam County Medical Society 1920 through 1924; member of Committee on Veterans' Affairs 1938 through 1940; member of War Participation Committee 1944 and 1945; delegate from Putnam county 1943.

EARL VAN REED, Lafayette. Secretary, Tippecanoe County Medical Society 1912 to 1916 inclusive; chairman of the Registration Committee 1933; member of Committee on Scientific Work 1937 and 1938; chairman, Committee on Scientific Work 1939; delegate from Tippecanoe county 1934 through 1945.

(On motion of Dr. W. R. Davidson, seconded by Dr. M. B. Catlett, the minutes of the previous meetings, as published in THE JOURNAL, were accepted.)

THE PRESIDENT: Article V of the Constitution gives the A. M. A. delegates the right to sit in the House of Delegates, have the privilege of the floor, but have no power to vote. This has been interpreted to include alternates also. They are:

Delegates	*Alternates*
H. G. Hamer, Indianapolis	K. R. Ruddell, Indianapolis
A. S. Giordano, South Bend	G. Collett, Crawfordsville
D. F. Cameron, Fort Wayne	N. M. Beatty, Indianapolis
F. S. Crockett, Lafayette	A. M. Mitchell, Terre Haute

All members of the association who desire to sit in on this meeting to hear the deliberations of the House are welcome.

In accordance with Chapter IX, Section 1, of the By-Laws of the association, reference committees have been appointed by the president and were published in the October JOURNAL and in the Handbook. These reference committees are to serve during this session and should not be confused with the all-year round standing committees. To these reference committees shall be referred all reports, resolutions and measures presented to the House of Delegates at this session, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted at the last meeting of the House of Delegates at 7:15 a. m., Thursday, October 31, for acceptance in the original or modified form, or for rejection. The Thursday morning breakfast meeting will be held in the Chateau Room, first floor, Claypool Hotel.

Each reference committee consists of five members, the first member named to be the chairman. Will you please stand as your names are called in order that the delegates may know who the members of the various committees are?

REFERENCE COMMITTEES

1946

1. **SECTIONS AND SECTION WORK:**
   Chairman, J. E. Dudding, Hope (Bartholomew).
   C. E. Weddle, Lebanon (Boone).
   J. R. Nash, Albion (Noble).
   Julia Thom, Spencer (Owen).
   J. Guy Hoover, Boonville (Warrick).
2. **RULES AND ORDER OF BUSINESS:**
   Chairman, V. L. Turley, Fowler (Benton).
   J. T. Carney, Jeffersonville (Clark).
   E. B. Lett, Loogootee (Daviess-Martin).
   J. H. Barrow, Dale (Spencer).
   Earl B. Jewell, Logansport (Cass).
3. **MEDICAL EDUCATION AND HOSPITALS:**
   Chairman, Bruce W. Stocking, Muncie (Delaware-Blackford).
   Herman Smelser, Connersville (Fayette-Franklin).
   W. G Pippenger, Brook (Jasper-Newton).
   P. Q. Row, Hammond (Lake).
   Roy A. Geider, Indianapolis (Marion).
4. **PUBLIC POLICY AND LEGISLATION:**
   Chairman, Harry L. Foreman, Indianapolis (Marion).
   A. T. Jones, Pendleton (Madison).
   C. E. Boyd, West Baden Springs (Orange).
   W. D. Inlow, Shelbyville (Shelby).
   F. R. N. Carter, South Bend (St. Joseph).
5. **PUBLICITY:**
   Chairman, Russell Lavengood, Marion (Grant).
   O. T. Scamahorn, Pittsboro (Hendricks).
   A. C. Yoder, Goshen (Elkhart).
   J. L. Allen, Greenfield (Hancock).
   M. B. Catlett, Fort Wayne (Allen).
6. **HYGIENE AND PUBLIC HEALTH:**
   Chairman, William H. Garner, New Albany (Floyd).
   L. W. Painter, Winchester (Randolph).
   Harold D. Caylor, Bluffton (Wells).
   Harry P. Ross, Richmond (Wayne-Union).
   S. M. Cotton, Goldsmith (Tipton).
7. **AMENDMENTS TO CONSTITUTION AND BY-LAWS:**
   Chairman, C. V. Rozelle, Anderson (Madison).
   Raymond C. Beeler, Indianapolis (Marion).
   Oran Province, Franklin (Johnson).
   Gordon A. Thomas, Lafayette (Tippecanoe).
   R. Lee Smith, Osgood (Ripley).
8. **REPORTS OF OFFICERS:**
   Chairman, O. G. Brubaker, North Manchester (Wabash).
   E. R. Clarke, Kokomo (Howard).
   G. L. Verplank, Gary (Lake).
   C. F. Briggs, Sullivan (Sullivan).
   R. B. Johnson, Rushville (Rush).
9. **COMMITTEE ON CREDENTIALS:**
   Chairman, C. M. Clark, Oakland City (Gibson).
   Floyd S. Napper, Scottsburg (Scott).
   Gilbert D. Rhea, Greencastle (Putnam).
   J. Frank Maurer, Brazil (Clay).
   John S. Hash, Noblesville (Hamilton).
10. **COMMITTEE ON MISCELLANEOUS BUSINESS:**
    Chairman, M. C. Topping, Terre Haute (Vigo).
    A. E. Stinson, Rochester (Fulton).
    King L. Hull, Bloomfield (Greene).
    A. A. Thompson, Tyner (Marshall).
    Frederick K. Allen, Salem (Washington).

These reference committees should organize immediately after the adjournment of the House today. Time will be given at the conclusion of this meeting for the chairman of each reference committee to announce on the floor of the House the time and place his committee is to meet. Each reference committee chairman, at the conclusion of this meeting, should turn over to the Executive Secretary a memorandum giving the time and place of his committee meeting in order that this information may be placed on the bulletin board at the registration desk.

Miss Kribs will be available at the headquarters office in the northeast corner of the exhibit hall to type reports of the reference committees, and all chairmen should have their reports typed before the last meeting of the House of Delegates.

Next we have the reports of officers. The address of the President, to be made before the general meeting on Wednesday, will be referred to the Reference Committee on Reports of Officers.

ADDRESS OF THE PRESIDENT-ELECT

DR. ROMBERGER:

Mr. President, Members of the House of Delegates:

I stand before you sincerely unpretending, deeply moved, and highly honored by having been chosen president of this great association for 1947. I am most appreciative.

As the time approaches for me to take office, I am keenly aware of the responsibilities entailed and of the many duties involved. Yet, I do not hesitate. For twenty-two consecutive years I have labored in this House, first as a delegate from Tippecanoe County, then successively as councilor, as chairman of the Council and a member of the Executive Committee, and for the past year as president-elect. Truly, it has been a labor of love, because I believe in organized medicine. I have learned many things, foremost among which is the fact that the Indiana State Medical Association is greater than any one individual. Year by year its organized activities roll on and on, ever and ever just a bit more intricately, ever and ever just a bit more effectively. The gravity and sincerity of purpose with which this House of Delegates has approached the many and varied problems posed before it during the past quarter of a century is worthy of admiration and commendation, and our organized strength in Indiana is fittingly attested by the results of your actions over the years. It could spawn only from a body of men whose ideals are the very highest.

The amount of work performed by this House and its committees and committee chairmen, by the Council and its Executive Committee, and by and through the executive officers and offices is prodigious. The chores are many and arduous. Praise for outstanding services rarely is sung. The same may be said of the component district and county societies—all are doing an outstanding job in scientific medicine for the betterment of the public weal.

As I review, therefore, the unified support and the kindly counsel which the medical profession of this great state always has given to its leadership, I am buoyed by the thought that a continuance of such worthy help and careful guidance will lead my feet into pleasant paths during the coming year.

My comment will be very brief. First, let us take a quick look at government, the truly democratic principles of the self-governed. One hundred fifty-nine years ago, in Philadelphia, the signing of the Constitution of the United States took place. Read it! Study it! Therein you will find our basic, fundamental organic law, a system of salutary checks and balances so necessary to a free government of and by a free people. It was written by our pioneer forefathers who had learned their lessons through bitter experience, mostly in foreign lands, and who had been guided by Almighty God and the wisdom of the ages as told in previous history.

Under this Constitution the original thirteen colonies developed and expanded and grew into this great country we call America, unquestionably the finest and the best.

You ask, "What has this to do with medical practice?" Behold! Came two great presidents; then a third, Thomas Jefferson, 1801-1809. In his autobiography, written more than a century and a quarter ago, expounding more fully upon the ramification of the principles of democracy, he advised:

"It is not by the consolidation or concentration of powers, but by their distribution that good government is effected. Were not this great country already divided into states, that distribution must be made, that each might do for itself what concerns itself directly and what it can so do better than a distant authority. Every state again is divided into counties, each to take care of what lies within its local bounds.

"Were we directed from Washington when to sow and when to reap, we should soon want bread."

Think! It may happen that we, as physicians of Indiana, duly organized, both at the state level and at the county society level, soon may be obliged to take a more positive stand in matters pertaining to our fundamental rights and constitutional liberties, and to avow: "We, the physicians of the sovereign State of Indiana, have the 'savvy' and the 'know-how' to practice medicine in this our great state; these are the principles, and these are the conditions and the terms. All for the betterment of the public welfare."

To be able to do this most effectively, we must have perfect organization! We must have unity! Unity of thought and opinion and action! Unity of decision! Also, we must have power, irresistible power; organized power to enforce respect for the American Way of medical practice in the public's own interest before any lay body, be it legislative or be it otherwise. Such is the power we need! Such power we must have!

The Indiana State Medical Association, through its constituent county societies, has an almost ideal and certainly a most rugged framework upon which

to build such power, if we will, all in accordance with the democratic principles of the self-governed. The essence of democracy is the ballot of an informed electorate. It behooves us, therefore, that every individual member of this association should be fully and thoroughly acquainted with the many serious problems now confronting our profession. Then and then only can he, as he should, discuss them intelligently in his own county society. The county society, after free and open debate, then makes its decision, and its delegate is instructed accordingly. This House of Delegates, with every county so represented, deliberates and resolves upon the necessary action. Such is the functioning of a true democracy. Such is the American Way. Yes, the leadership must come from the top, but the irresistibly surging tide of strength and the lashing wave of power must come from beneath, from the individual physician, through his county medical society.

Indiana can be justly proud of the record of achievement attained by its physicians who at great sacrifice served with the armed forces during the recent war. These men now have returned. It is my earnest personal hope that they will engage largely and still more largely in formulating the policies and in conducting the affairs of this association. To them is yielded the torch most gladly; for they, the younger members of our profession, are the men most deeply concerned with the future of medical practice, and upon their shoulders will fall the ever-increasing burden of safeguarding the public weal, without undue sacrifice of the American Way of medical practice so faithfully preserved until now.

With due humility, yet from the very depths of experience, I vigorously aver that I am most certain of three basic, fundamental concepts: (1) Strong county societies make a strong state association. (2) Thorough and still more thorough dissemination of knowledge, plus free and open debate, is the essence of democracy among free men, free physicians. (3) Only by the constant infusion of young blood into the body politic of our association can it continue to increase in strength and in stature. Toward these simple objectives we must, perforce, rededicate our every effort year by year, so that the Indiana State Medical Association, a deep-rooted oak, may tower higher and ever higher in its majestic grandeur and in its simple dignity and in its well-deserved distinction.

I make no specific recommendations to this House of Delegates. I have complete confidence and an abiding faith in the wisdom of its decisions. Toward the fulfillment of its directives, I pledge my every sincere effort.

REPORT OF EXECUTIVE SECRETARY

Referred to Reference Committee on Reports of Officers.

REPORT OF TREASURER

Referred to Reference Committee on Reports of Officers.

REPORT OF CHAIRMAN OF COUNCIL

Referred to Reference Committee on Reports of Officers.

REPORTS OF STANDING AND SPECIAL COMMITTEES

COMMITTEE ON CREDENTIALS

Referred to Reference Committee on Credentials.

EXECUTIVE COMMITTEE

DR. CLEON A. NAFE, Chairman: The committee has this supplemental report to make. At the Executive Committee meeting October 28, 1946, our executive secretary read the following resolution which was unanimously approved and passed at the Twenty-eighth National American Legion Convention, in San Francisco, October 4, 1946:

"WHEREAS: Veterans who have served in the armed forces now have available to them hospital and medical care provided by the United States Government; and

"WHEREAS: There are countless voluntary health insurance plans now being offered by the physicians and the insurance companies; and

"WHEREAS: Proposed plans of compulsory health insurance would increase the tax burden and bring about regimentation of the medical profession; and

"WHEREAS: All forms of compulsion are repugnant to our American way of life since our liberties and opportunities would be circumscribed;

"NOW, THEREFORE, BE IT RESOLVED: That the National Assembly of the American Legion hereby expresses its opposition to compulsory health insurance."

The Legislative Committee and the Executive Committee jointly recommend to the members of this House of Delegates that they officially recognize this action of the American Legion and address a communication to their National and State (Indiana) officers commending them for their sane attitude concerning health insurance as outlined in their resolution.

CLEON A. NAFE, *Chairman,*
Executive Committee.
NORMAN M. BEATTY,
J. WILLIAM WRIGHT,
Co-Chairmen,
Legislative Committee.

I have one other announcement. I want to call to your attention the paragraph in the Executive Committee Report concerning group malpractice insurance, page 48 in the Handbook. We have had very fine co-operation with the St. Paul Mercury Indemnity Company. We have the word from that office today that they are going to reduce their base premium rate to $28.00 for $10,000 to $30,000 coverage. To date the company has 344 policies in effect covering the members of the association, which is not as large a percentage as the committee

had hoped to have by this time. If such a plan is to be successful, it should be supported by the great majority of the members of our society.

COMMITTEE ON ARRANGEMENTS

Referred to Reference Committee on Miscellaneous Business.

COMMITTEE ON SCIENTIFIC WORK

Referred to Reference Committee on Sections and Section Work.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Referred to Reference Committee on Public Policy and Legislation.

BUREAU OF PUBLICITY

Referred to Reference Committee on Publicity.

CIVIC AND INDUSTRIAL RELATIONS

Referred to Reference Committee on Public Policy and Legislation.

MEDICAL EDUCATION AND HOSPITALS

Referred to Reference Committee on Medical Education and Hospitals.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

Referred to Reference Committee on Public Policy and Legislation.

JOURNAL PUBLICATION COMMITTEE

Referred to Reference Committee on Reports of Officers.

SECRETARIES' CONFERENCE

Referred to Reference Committee on Miscellaneous Business.

SCIENTIFIC EXHIBIT

Referred to Reference Committee on Sections and Section Work.

NECROLOGY AND HISTORY

Referred to Reference Committee on Miscellaneous Business.

PHYSICAL FITNESS

Referred to Reference Committee on Hygiene and Public Health.

MENTAL HEALTH

Referred to Reference Committee on Hygiene and Public Health.

STUDY OF LAY ACTIVITY IN MEDICAL PRACTICE

Referred to Reference Committee on Public Policy and Legislation.

ADVISORY COMMITTEE TO THE BUREAU OF MATERNAL AND CHILD HEALTH OF THE INDIANA STATE BOARD OF HEALTH

Referred to Reference Committee on Public Policy and Legislation.

LIAISON COMMITTEE OF THE DIVISION OF SERVICES FOR CRIPPLED CHILDREN

Referred to Reference Committee on Public Policy and Legislation.

AUDITING COMMITTEE

Referred to the Council.

CONTROL OF CANCER

Referred to Reference Committee on Hygiene and Public Health.

VENEREAL DISEASE

Referred to Reference Committee on Hygiene and Public Health.

INDUSTRIAL HEALTH

Referred to Reference Committee on Hygiene and Public Health.

COMMITTEE ON INDIANA INTER-PROFESSIONAL HEALTH COUNCIL

Referred to Reference Committee on Miscellaneous Business.

ANTI-TUBERCULOSIS COMMITTEE

Referred to Reference Committee on Hygiene and Public Health.

CONSERVATION OF VISION

Referred to Reference Committee on Hygiene and Public Health.

POSTWAR COMMITTEE

Referred to Reference Committee on Miscellaneous Business.

PHYSICAL THERAPY

Referred to Reference Committee on Public Policy and Legislation.

MEDICAL RELIEF

Referred to Reference Committee on Public Policy and Legislation.

RURAL MEDICAL CARE

Referred to Reference Committee on Public Policy and Legislation.

HARD OF HEARING

Referred to Reference Committee on Hygiene and Public Health.

POSTWAR MEDICAL SERVICE

Referred to Reference Committee on Miscellaneous Business.

MEDICAL ECONOMICS

Referred to Reference Committee on Miscellaneous Business.

MEDICAL ADVISORY COMMITTEE FOR VOCATIONAL REHABILITATION

Referred to Reference Committee on Miscellaneous Business.

CENTENNIAL CELEBRATION

Referred to Reference Committee on Publicity.

BUILDING COMMITTEE

Referred to Reference Committee on Miscellaneous Business.

ESTABLISHMENT OF BOARD OF CERTIFICATION FOR THE GENERAL PRACTICE OF MEDICINE

Referred to Reference Committee on Medical Education and Hospitals.

VETERANS' AFFAIRS COMMITTEE

Referred to Reference Committee on Miscellaneous Business.

STATE FAIR

Referred to Reference Committee on Publicity.

VETERANS' CARE COMMITTEE

Referred to Reference Committee on Miscellaneous Business.

PREVENTION OF TRAFFIC ACCIDENTS

Referred to Reference Committee on Public Policy and Legislation.

REVISION OF THE CONSTITUTION

Referred to Reference Committee on Amendments to the Constitution and By-Laws.

COMMUNICATIONS

THE PRESIDENT: Communications that have been received during the year have been referred to the various standing committees or the Council and have been disposed of. This indicates active and working committees.

NEW BUSINESS

DR. N. K. FORSTER, Hammond: I have the following resolution to offer regarding the National Board of Medical Examiners:

WHEREAS, the licensing authorities of forty-four states, the District of Columbia and the territories and possessions of Alaska, Hawaii, Puerto Rico and the Canal Zone accept the certificate of the National Board of Medical Examiners as an adequate qualification for a medical license, and

WHEREAS, the examinations of the National Board in the basic sciences are accepted in lieu of the examinations in those subjects required by the basic science boards of eight of the eighteen states requiring a basic science certificate, and

WHEREAS, the requirements for admission to the National Board examinations include and in some cases exceed the standards for admission to examination set up by state boards of medical examinations, and

WHEREAS, the almost universal recognition of the examinations of the National Board is evidenced by the acceptance of the board's examinations by many medical schools as part of their own examination and promotion procedure, and, in fact, is so required by many medical schools, and

WHEREAS, the membership of the National Board is made up of representatives from the Federation of State Medical Boards of the United States, the Association of American Medical Colleges, the Council on Medical Education and Hospitals of the American Medical Association, the federal services and members elected at large, and

WHEREAS, the National Board has consistently maintained a high standard of qualification and ability throughout twenty-eight years of its existence, and

WHEREAS, the Indiana State Board of Medical Registration and Examination has, for the past ten years, accepted the certificate of the National Board of Medical Examiners, upon review of individual applicant's examinations, as sufficient evidence for granting of reciprocity or a medical license to practice in this state by exemption, and

WHEREAS, the newly created Board of Medical Registration and Examination of Indiana, acting under advice of the Attorney General, at present does not accept the certificate of the National Board in reciprocity or for granting of a medical license by exemption, and

WHEREAS, the members of the Board of Medical Registration and Examination of Indiana, at their last meeting on October 8, 1946, expressed their approval of acceptance of the certificate of the National Board, where adequate safeguards are set up or where the State Board would review the examination of individual applicants or otherwise pass upon the qualifications: Therefore be it

RESOLVED, that the House of Delegates of the Indiana State Medical Association go on record as approving the purposes and activities of the National Board of Medical Examiners, and request the Board of Medical Registration and Examination of Indiana to endeavor to find the necessary power within the Medical Practice Act to allow their acceptance of the certificate of the National Board for reciprocity or medical license by exemption, and be it further

RESOLVED, that should such power be lacking, a bill, granting such power, be prepared by the Legislative Committee, with the assistance of the Attorney of the Association, and meeting the approval of the members of the Board of Medical Registration and Examination of Indiana, for presentation at the next session of the legislature.

(Referred to Reference Committee on Medical Education and Hospitals.)

SUPPLEMENTARY REPORT OF CHAIRMAN OF COUNCIL

Dr. A. M. Mitchell, Terre Haute, read the resolution prepared by the Committee for the Study of Nursing Service, which was adopted by the Council at its meeting at 12:30 p. m., October 29, and which the Council referred to the House of Delegates for its consideration.

(Referred to Reference Committee on Medical Education and Hospitals.)

Dr. Mitchell: After studying the financial situation of the state association, and considering the fact that the cost of publishing The JOURNAL has gone up and probably will go higher, and also the fact that we probably will have to initiate a more active public relations program, the Council deems it advisable that the dues shall be raised from $10.00 to $15.00.

(Referred to the Reference Committee on Reports of Officers.)

Another thing, Mr. Hendricks left the employ of the association the first of May and at that time Mr. Smith was appointed full-time executive secretary and managing editor of The JOURNAL. The Council thought it would be very appropriate that we do something for Mr. Hendricks to sort of tie him in with the state society, and they voted that he should be made Executive Secretary Emeritus. I move that this honorary title be voted upon and confirmed by this House of Delegates. (Motion seconded by Dr. G. J. Garceau, and carried.)

REPORT OF MUTUAL MEDICAL INSURANCE, INC.

Dr. W. U. Kennedy, New Castle, president of Mutual Medical Insurance, Inc., reported as follows:

On January 28, 1946, the House of Delegates approved and directed the formation of a mutual indemnity insurance company by unanimous vote.

In compliance with the directive, a temporary organization was formed the same day. The temporary officers prepared the required forms, which in due course were approved and a charter was issued by the State.

Permanent organization then was effected, the first Board of Directors being the Councilors and Drs. Portteus, Crockett, Romberger and Ferrell.

Dr. W. U. Kennedy was elected as President, Dr. W. H. Howard as Vice-President, Dr. Walter Portteus as Secretary, and Dr. A. F. Weyerbacher as Treasurer. Management was placed in the hands of an Executive Committee of five.

Capital funds amounting to $83,500 were paid in by Indiana physicians, eighty-five counties out of ninety-two being represented.

The entire cost of organization was held to 2 per cent instead of the allowed 10 per cent.

The Blue Cross organization was employed to solicit members and to collect the payments. Their entire force was thrown into an intensive solicitation program which procured the $25,000 in prepaid premiums and on September first, the State Insurance Department issued a permit to begin business.

The initial policies in effect on September first were 1,800.

Throughout September the enrollment program was carried on so well that on October first, over 45,000 persons were covered by our policies. Final reports for October are not available, but a conservative estimate is that on November first 60,000 persons will be covered.

At this time our Company stands ninth in the United States, though but eight weeks in operation.

It is our expectation that by January first we will be covering 100,000 persons and by our first year-end we should be at least fourth in numerical standing. The growth of our company has been almost unbelievably rapid, testifying both to the public acceptance and need, and to the soundness of our planning. We are told by our representatives in both houses of Congress that we are demonstrating the desire and the ability of the medical profession to meet the demands of the public and so fortifying them in opposing socialized medicine by concrete proofs of our intentions and capacity.

The doctors of Indiana are doing their share.

(Referred to Reference Committee on Public Policy and Legislation.)

RESOLUTION ON INDIANA UNIVERSITY SCHOOL OF MEDICINE

Dr. Gordon A. Thomas, Lafayette: I wish to introduce the following resolution which was passed unanimously by the Tippecanoe County Medical Society at its regular meeting on September 10, 1946:

WHEREAS, The Indiana University School of Medicine is divided in location with the first year at Bloomington and the remaining three years at Indianapolis; and

WHEREAS, This division is not conducive to the best of medical training; and

WHEREAS, Students of the first year miss a great amount of medical atmosphere and the correlation of basic science with clinical conditions; and

WHEREAS, Students of the remaining three years do not have the opportunities of reviewing basic sciences or serving as assistants in the various basic sciences; and

WHEREAS, Better teaching facilities could be secured and made available to undergraduates, post-graduates and graduates in medicine; therefore

RESOLVED, That the Indiana State Medical Association go on record of favoring the moving of the first year of medicine to the Medical Center at Indianapolis as soon as is possible.

RESOLVED, That the Medical Center be placed under its own supervision and own budget that it may then be able to secure the best of medical talent for teaching.

RESOLVED, That a copy of this resolution be forwarded to each trustee of Indiana University.

(Referred to Reference Committee on Medical Education and Hospitals.)

Dr. Minor Miller: At the health officers' meeting this afternoon they took some action that they felt should be reported to the House of Delegates. There is some legislation that is proposed by the Board of Health to which the health officers took exception. One of them is the proposed law to empower the Board of Health to set up district health offices as it may see fit throughout the different parts of the state. It was the feeling of the health officers that this was undesirable, that it was much better to expend the time and effort in strengthening our local health departments rather than setting up district health offices.

Another law that is proposed is in favor of single and multiple county health units throughout the different sections of the state. Only in the proposal it was not stated that the Boards of Health now set up would be manned by a majority of persons holding an M. D. license. The health officers felt that that should be put in.

(Referred to Reference Committee on Public Policy and Legislation.)

RESOLUTION ON EDUCATIONAL FACILITIES FOR CRIPPLED CHILDREN

Dr. Clay A. Ball, Muncie: At the last meeting of the Delaware-Blackford County Medical Society a resolution was adopted that the State of Indiana through the Legislature be asked to make more adequate provision for the training and education of crippled children. Many of you probably know that it is almost impossible in some

counties and cities for crippled children to receive adequate education. Families are moving from our state because they are unable to get adequate teaching for their children. I want to present this resolution:

WHEREAS, Under our present state educational system, facilities for the education of the crippled child are inadequate;

WHEREAS, It is recognized that the proper education of the crippled child, as well as proper medical care, is extremely important for the welfare of the child and society in general; be it

RESOLVED, That the delegates of the Delaware-Blackford County Medical Society be instructed to bring a resolution that the Indiana State Legislature take action to provide proper educational facilities for the crippled child, before the next meeting of the House of Delegates of the Indiana State Medical Association.

Bruce W. Stocking, M.D., Secretary,
Delaware-Blackford County Medical Society.

(Referred to Reference Committee on Hygiene and Public Health.)

Dr. Norman M. Beatty, Indianapolis, co-chairman of the Committee on Public Policy and Legislation, spoke at this time on legislative matters.

Dr. Lowell W. Painter, Winchester: It has been suggested that a resolution might be presented to the House of Delegates for the consideration of the committee to which this is to be referred, to bring out a discussion which may or may not prove to be of value:

BE IT RESOLVED: That the Indiana State Medical Association express its belief that the best interests of medical education in Indiana will be served by the employment of a physician adequately trained and experienced in medical school administration, who is at present working in a locality outside Indiana to serve as full-time dean in Indiana University School of Medicine.

(Referred to Reference Committee on Medical Education and Hospitals.)

No further business appearing, on motion of Dr. George R. Daniels, duly seconded, the House of Delegates adjourned until 7:15 a. m., Thursday, October 31, 1946.

HOUSE OF DELEGATES

(Indianapolis Session, 1946)

SECOND MEETING

The second meeting of the House of Delegates, a breakfast meeting, was held October 31, 1946, in the Chateau Room, Claypool Hotel, Indianapolis, convening at 7:15 a.m.; the president, Dr. J. E. Ferrell, presiding.

It was taken by consent that the attendance slips signed by the delegates at the door should constitute the roll call.

County	*Delegates*
Adams	Ben Duke, Decatur
Allen	M. B. Catlett, Fort Wayne
	Arnold H. Duemling, Fort Wayne
	William R. Clark, Fort Wayne
Bartholomew	J. E. Dudding, Hope
Boone	Charles O. Weddle, Lebanon
Carroll	M. R. Adams, Flora
	C. L. Wise, Camden (alternate)
Cass	Earl B. Jewell, Logansport
Clark	J. T. Carney, Jeffersonville
Clay	J. F. Maurer, Brazil
Dearborn-Ohio	Charles N. Manley, Rising Sun
Delaware-Blackford	Clay A. Ball, Muncie
	Bruce W. Stocking, Muncie
Dubois	S. L. McKinney, Huntingburg
Elkhart	S. T. Miller, Elkhart
	A. C. Yoder, Goshen
Fayette-Franklin	F. B. Mountain, Connersville
	H. N. Smith, Brookville
Floyd	William H. Garner, New Albany
Fulton	A. E. Stinson, Rochester
Gibson	C. M. Clark, Oakland City
Grant	Russell W. Lavengood, Marion
Hamilton	John S. Hash, Noblesville
Hancock	Joseph L. Allen, Greenfield
Harrison	William E. Amy, Corydon
Hendricks	O. T. Scamahorn, Pittsboro
Henry	Walter M. Stout, New Castle
Howard	Elton R. Clarke, Kokomo
Huntington	G. M. Nie, Huntington
Jackson	G. R. Gillespie, Brownstown
Jasper-Newton	W. G. Pippenger, Brook
Jay	George V. Cring, Portland
Johnson	O. A. Province, Franklin
Lake	J. Robert Doty, Gary
	H. W. Eggers, Hammond
	Ray Elledge, Hammond
	P. Q. Row, Hammond
Lawrence	Claude Dollens, Oolitic
Madison	C. V. Rozelle, Anderson
Marion	Raymond C. Beeler, Indianapolis
	William M. Dugan, Indianapolis
	Harry L. Foreman, Indianapolis
	G. J. Garceau, Indianapolis
	Roy A. Geider, Indianapolis
	E. V. Hahn, Indianapolis
	Foster J. Hudson, Indianapolis
	Marlow W. Manion, Indianapolis
	L. T. Meiks, Indianapolis
	Harvey Sigmond, Indianapolis
	Chester A. Stayton, Indianapolis
	Charles F. Thompson, Indianapolis
	J. M. Whitehead, Indianapolis
Marshall	A. A. Thompson, Tyner
Miami	F. M. Lynn, Peru
Montgomery	George A. Collett, Crawfordsville
Noble	J. R. Nash, Albion
Orange	C. E. Boyd, West Baden Springs
Parke-Vermillion	S. C. Darroch, Cayuga
Pike	G. A. Dickinson, Petersburg
Porter	John R. Frank, Valparaiso
Posey	William B. Challman, Mt. Vernon
Pulaski	C. E. Linton, Medaryville
Putnam	G. D. Rhea, Greencastle
Ripley	R. Lee Smith, Osgood
Rush	Melvin H. Denny, Rushville
St. Joseph	F. R. Nicholas Carter, South Bend
	A. S. Giordano, South Bend
Scott	Floyd S. Napper, Scottsburg
Shelby	W. D. Inlow, Shelbyville
Tippecanoe	O. L. McCay, Romney
	Gordon A. Thomas, Lafayette
Vanderburgh	C. W. Cullnane, Evansville
	C. C. Herzer, Evansville
	Minor Miller, Evansville
Vigo	Ernest O. Nay, Terre Haute
	M. C. Topping, Terre Haute
Wabash	O. G. Brubaker, North Manchester

County	*Delegates*
Warrick	J. Guy Hoover, Boonville
Washington	Frederick K. Allen, Salem
Wayne-Union	Harry Plummer Ross, Richmond
	W. A. Thompson, Liberty
Whitley	B. F. Pence, Columbia City

COUNCILORS

1st District—I. C. Barclay, Evansville
3rd District—A. P. Hauss, New Albany
6th District—W. U. Kennedy, New Castle
7th District—C. J. Clark, Indianapolis
8th District—E. H. Clauser, Muncie
9th District—W. Dodds, Crawfordsville
11th District—C. S. Black, Warren
13th District—Alfred Ellison, South Bend

PAST PRESIDENTS

W. R. Davidson, Evansville
E. M. Shanklin, Hammond
Charles N. Combs, Terre Haute
G. R. Daniels, Marion
F. S. Crockett, Lafayette
R. L. Sensenich, South Bend
K. R. Ruddell, Indianapolis
A. M. Mitchell, Terre Haute
C. H. McCaskey, Indianapolis
N. K. Forster, Hammond

OFFICERS

J. E. Ferrell, Fortville, president
Floyd T. Romberger, Lafayette, president-elect
A. F. Weyerbacher, Indianapolis, treasurer
Thomas A. Hendricks, Chicago, executive secretary emeritus
Ray E. Smith, executive secretary

DELEGATE TO A.M.A.

H. G. Hamer, Indianapolis

ELECTION OF OFFICERS

Election of officers resulted as follows:

President-elect, 1947:—Cleon A. Nafe, Indianapolis
Treasurer:—A. F. Weyerbacher, Indianapolis
Delegates to A. M. A., for term expiring
December 31, 1948:—H. G. Hamer, Indianapolis
A. S. Giordano, South Bend
Alternates:—Karl R. Ruddell, Indianapolis
George Collett, Crawfordsville

PLACE OF MEETING

Place of meeting for 1947:—French Lick

ELECTION OF COUNCILORS

Third District
A. P. Hauss, New Albany, re-elected

Sixth District
W. U. Kennedy, New Castle, re-elected

Ninth District
Wemple Dodds, Crawfordsville, re-elected

Twelfth District
Paul A. Garber, South Whitley

Second District

Attention was called to the fact that Dr. J. H. Crowder, Sullivan, was elected by the House of Delegates to fill Dr. H. C. Wadsworth's unexpired term which ended December 31, 1945. The Second District Medical Society met June 5, 1946, but held no election. On motion of Dr. C. N. Combs, seconded by Dr. M. C. Topping, Dr. Crowder was continued as councilor of the Second District until such time as the Second District Society holds an election.

VETERANS' RESOLUTIONS

THE PRESIDENT: At this time we have two resolutions that the Servicemen's Section would like to present to this House of Delegates. It is out of order; they should have been presented at the first meeting of the House of Delegates, and, as you know, they should have been referred to a reference committee. But these are from the veterans, and we wish to do everything that is possible for them. With your consent we will have these resolutions read. (Taken by consent.)

DR. CHARLES F. THOMPSON: Mr. President, and members of the House of Delegates: These two resolutions are presented from the meeting of the Servicemen's Section held yesterday afternoon; hence the delay in presenting them to this body. The first one:

"WHEREAS, The methods of procurement and assignment of physicians for the armed forces during the past emergency created in many instances inadequacies in utilization of such medical service,

"BE IT RESOLVED, That the House of Delegates of the Indiana State Medical Association promote present plans of the American Medical Association to preclude and avoid such inadequacies in the event of a future national emergency." From the Servicemen's Section of the Indiana State Medical Association.

Resolution No. 2:

"WHEREAS the Veterans Administration, Navy and Army have and will be appointing civilian consultants in the various specialties;

"WHEREAS veterans eminent in the various specialties are available;

"BE IT RESOLVED: That all civilian consultants in the Veterans Administration, Navy and Army should be selected from among those physicians who have been former members of the Armed Forces."

(Dr. W. A. Thompson moved that the rules be suspended and that these resolutions be passed. Motion seconded by Dr. George Daniels, and carried.)

DR. R. L. SENSENICH: I would like to tell you something about what is being done. Plans are not only under way, but the cards are practically in the mail, by which every ex-serviceman will receive a card from the American Medical Association with questions covering all the things that have had to do with his service, the conditions, and give him an opportunity to make suggestions or complain of whatever he has been unhappy about.

When the cards are returned, they will be turned over to the Committee on National Emergency. I would say that it is apparent that in any future war the problems will be vastly different than they have been any time in the past and that there must be better utilization of medical

manpower or there will not be a sufficient number of physicians to properly serve both the armed forces and the civilians.

There cannot be a continuation of the duplication of units by which the Army, in one instance, will have a fully-manned hospital, and a few miles away an equal sized unit under the Navy, and neither one of them occupied. There are just not enough doctors to do that kind of thing. So that probably, if the armed forces are willing to accept it, in any reorganization we will press for a revision and change of such kind that the medical service will no longer be under the Service of Supply in the Army, but that there will be, insofar as is possible, a division of the medical service, of such kind, that it will make it available to either service and with the greatest possible fluidity.

DR. FLOYD T. ROMBERGER: I had the very great pleasure to sit with the veterans section yesterday at luncheon, and I wonder whether this House would not like to amend that second resolution by one simple phrase: "Where such properly qualified officer is available." Now, the reason for that is perfectly obvious. There may be a Veterans Facility established where insufficient men are available who had served with the armed forces, and it would be an injustice to the GI to not have readily assignable in the nearby neighborhood a physician who is duly qualified. There's another far-reaching consequence that maybe we should consider, and that is this: These GI's, and these veterans' services to the GI, are going to go on for twenty, thirty, maybe forty years. If we don't have another war, there may be a scarcity of qualified ex-service physicians, and I think it is only fair to government, and I think it is only fair to the GI himself, that he has the best service which is available. I just am offering that as a suggestion to this House.

(Dr. Charles F. Thompson moved that Dr. Romberger's addition be included in the above resolution. Motion duly seconded, and passed.)

REPORTS OF REFERENCE COMMITTEES

SECTIONS AND SECTION WORK

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Committee on Sections and Section Work wishes to commend:

(1) Dr. James O. Ritchey and his Committee on Scientific Work for their excellent and highly instructive scientific program and for their choosing of subjects both timely and profitable, and their very excellent presentation.

(2) Dr. C. G. Culbertson and his Committee on Scientific Exhibit for the arranging of the very interesting and instructive scientific exhibits.

J. E. DUDDING, M.D., *Chairman*
CHARLES O. WEDDLE, M.D.
J. R. NASH, M.D.
JULIA THOM, M.D.
J. GUY HOOVER, M.D.

DR. DUDDING: I move the adoption of this report (Motion seconded, and passed.)

RULES AND ORDER OF BUSINESS

(Nothing having been referred to this Committee, there was no report.)

MEDICAL EDUCATION AND HOSPITALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

We move the acceptance of the report of the Committee on Medical Education and Hospitals as printed on page 60 of the Handbook. (Motion carried for adoption of this section.)

We move the acceptance of the report of the Committee on Establishment of the Board of Certification for the General Practice of Medicine as printed on pages 111 and 112 of the Handbook. We believe that the members of this committee are to be commended upon the expedition with which they have carried out the directives given them at last year's meeting of the House of Delegates. (Motion seconded by Dr. Rozelle, and carried.)

We move the adoption by the House of the resolution regarding the National Board of Medical Examiners as read by Dr. Forster on its original submission. (Seconded by Dr. Garceau, and carried.)

The resolution presented by Dr. Gordon Thomas in regard to the Indiana University School of Medicine duplicates material passed by this House at its last meeting on the recommendation of Dr. Forster. The same sentiments, namely the desirability of a transfer of the first year of Indiana University School of Medicine to Indianapolis form a part of the platform of the state JOURNAL. Nevertheless, your committee recommends the passage of this resolution and the sending of a copy to each of the trustees of Indiana University and to Dr. Herman Wells. (Motion carried for adoption of this section of report.)

(At this point the resolution presented by the Committee for the Study of Nursing Service was read. Dr. Stocking stated that this resolution did not meet with the approval of the reference committee. He presented an amended resolution from the reference committee, with the motion that it be adopted. Motion seconded. Discussed by Drs. Clark, Sensenich, Crockett, Hauss, Pippenger, Scamahorn, Daniels, Doty and Giordano. On standing vote, motion for adoption of the amended resolution was lost.)

(Dr. Stocking then read the original resolution of the Committee for the Study of Nursing Service, and moved its adoption. Motion seconded by Dr. Rozelle. On standing vote, this motion was lost.)

Your reference committee believes that it is not in order for this society to recommend the selection of a new dean for Indiana University School of Medicine from outside the State of Indiana or from inside the State of Indiana. Otherwise a majority of the committee favors

the adoption of the resolution submitted by Dr. Painter of Randolph county. The resolution as changed by the committee reads as follows:

"Resolved, That the Indiana State Medical Association herewith expresses its belief that the best interests of medical educatian in Indiana will be served by the employment of a physician adequately trained and experienced in medical education and medical school administration to serve as full-time dean of the Indiana University School of Medicine."

(Motion carried for adoption of this section.)

Your reference committee believes that the formation of an Indiana University Medical School Alumni Association, which is now proceeding, should afford a source of influence in the affairs of the school and deserves the support of every alumnus of the school.

Bruce W. Stocking, M.D., *Chairman*
Herman Smelser, M.D.
W. G. Pippenger, M.D.
P. Q. Row, M.D.
Roy A. Geider, M.D.

(Dr. Stocking moved the acceptance of the report as a whole as amended. Motion seconded by Dr. Daniels, and carried.)

Dr. C. H. McCaskey: About the nursing situation, this committee has done a considerable amount of work and knows the details of it, and I sugest that this committee, through whatever legal process is necessary, be continued and allowed to meet and confer with the State Nurses Association on this problem and see what can be worked out by the time we meet again. I make that as a motion. (Motion seconded, and carried.)

PUBLIC POLICY AND LEGISLATION

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your Reference Committee on Public Policy and Legislation submits the following report:

Report of Committee on Public Policy and Legislation. We agree with the report and commend the committee members for their sincere efforts. (Motion for adoption of this report carried.)

Report of the Committee on Civic and Industrial Relations. No report handed in.

Report of the Council on Medical Service and Public Relations. These committeemen have done some extensive work as indicated by their report; we highly commend their efforts. (Motion for adoption carried.)

Report of the Advisory Committee to the Division of Maternal and Child Health of the Indiana State Board of Health. This is an excellent report. (Motion for adoption of this report carried.)

Report of the Committee for the Study of Lay Activity of Medical Practice. A very satisfactory report. (Motion for adoption carried.)

Report of the Medical Relief Committee. No report.

Report of the Committee on Rural Medical Care. An excellent report. (Motion for adoption carried.)

Report of the Committee on Prevention of Traffic Accidents. Their work was very commendable. (Motion for adoption of this report carried.)

Report of the Committee on Physical Therapy. No report.

Report of the Liaison Committee of the Division of Services for Crippled Children. No report.

Our report on the resolution submitted by Dr. Cleon A. Nafe, chairman of the Executive Committee, which was unanimously approved and passed at the twenty-eighth national American Legion Convention in San Francisco, October 4, 1946, is as follows:

We believe that this resolution is one of the finest supports which organized medicine could possibly receive. We are glad to recommend to this House of Delegates that they officially recognize this action of the American Legion and address a communication to their national and state (Indiana) officers commending them for their sane attitude concerning health insurance as outlined in their resolution. (Dr. Foreman's motion for adoption of this resolution was duly seconded and passed.)

The report of the Mutual Medical Insurance, Inc., presented by Dr. W. U. Kennedy, president, demands our highest respect and commendation. It indicates a most unusual, rapid and satisfactory progress that could be hoped for. Congratulations to Dr. Kennedy and his co-workers. (Motion for adoption of this report carried.)

In reference to the report of Dr. Minor Miller of Evansville, your reference committee approves the stand of the State Health Officers' Association.

Respectfully submitted by your committee.

Harry L. Foreman, M.D., *Chairman.*
A. T. Jones, M.D.
C. E. Boyd, M.D.
W. D. Inlow, M.D.
F. R. N. Carter, M.D.

Dr. Foreman: I move that this statement of Dr. Miller of Evansville, in the nature of a resolution, be adopted by this House of Delegates. (Motion seconded by Dr. Rozelle. Discussed by Drs. Beatty and Carter, and Dr. Foreman's motion for adoption of this section of the report was passed.)

Dr. Foreman: I move you the adoption of this report as a whole. (Motion seconded, and passed.)

(The public health program then was discussed by Drs. Ross, Hauss and Daniels.)

Dr. Hauss: I move that the question of the health legislation be reconsidered. (Motion seconded by Dr. Garceau and carried.)

(Dr. Rozelle moved that this matter be referred to the Council at its January meeting. Motion seconded by Dr. Mitchell. Further discussion followed by Drs. Mitchell, Dudding, Nafe and

Clarke, Howard county, and the motion made by Dr. Rozelle was passed.)

PUBLICITY

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Reference Committee upon Publicity wishes to indorse the activities of the Bureau of Publicity for the year of 1946.

We especially wish to commend the newspaper releases and the column entitled "Hints on Health" for the weekly newspapers throughout the state. We believe this develops a kindly attitude of the laity for the members of the medical profession and also helps to give the general public useful information upon matters pertaining to health. More physicians should be encouraged to write articles for this column. We feel there is a lot of good talent that is lying dormant.

The committee is to be thanked for news concerning the annual session, the Secretaries Conference, Indiana sightseeing trips to the A.M.A. meeting at San Francisco.

During the year the fifteen-minute radio broadcasts disseminated a considerable amount of knowledge, especially the afternoon program for the ladies. This we believe should be encouraged and helps keep American Medicine in the thousands of homes throughout the nation. Many homes could only be reached by such an agency.

Many speakers were provided for medical societies, service clubs and Parent-Teacher Associations.

The commiteee wishes to indorse the Centennial Celebration Committee and the publication of the Memorial Volume which is being ably edited by Mrs. Dorothy Russo. The committee feels that Dr. B. D. Myers of Bloomington, Indiana, should be asked to assist or act as a consultant to Mrs. Russo, as Dr. Myers is writing a history of the Medical Schools of Indiana and is quite conversant and familiar with the Medical History of this State.

The committee feels that the work of the Committee at the State Fair should be indorsed in its entirety as valuable medical data was obtained.

The reference committee had some questions concerning the mass blood-pressure readings, inasmuch as the environment and circumstances at the moment of the reading may not always have resulted in a true reading.

Russell W. Lavengood, M.D., *Chairman.*
M. B. Catlett, M.D.
A. C. Yoder, M.D.
O. T. Scamahorn, M.D.
J. L. Allen, M.D.

Dr. Lavengood: I move that this report be accepted. (Motion duly seconded, and carried.)

HYGIENE AND PUBLIC HEALTH

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your reference committee wishes to submit the following report after carefully reviewing the reports of the following committees:

Report of the Committee on Physical Fitness. Your reference committee wishes to express its deepest regret and concern over the fact that such an important feature of the work of the physicians received no more consideration by this permanent committee. We move the adoption of the report as given in the Handbook, page 71. (Motion seconded by Dr. Nay, and carried.)

Report of Committee on Mental Health. The reference committee has read with interest this report and wishes to commend the Committee on Mental Health for its excellent report and for the amount of time and effort given to the study of mental health needs of the citizens of the State of Indiana. We move the adoption of this report as printed in the Handbook, pages 71 to 75 inclusive. (Motion seconded by Dr. Rozelle, and carried.)

Report of Committee on Control of Cancer. Your reference committee has carefully studied the report of the Committee on the Control of Cancer and wishes to express its appreciation for the services and the time and effort spent by this committee concerning this very important health menace. We approve the majority and minority reports in toto and wish to express appreciation for Doctor Giordano's understanding of the entire cancer problem and for the time he has spent in visiting various clinics established under the direction of the American Cancer Society. In a conversation with Doctor Giordano it was brought out at our committee meeting that emphasis should be given to the qualifications of the examining physician and history-taker in each cancer clinic. This committee agrees with Doctor Giordano's advice that only physicians well qualified to take histories and make physical examinations be permitted to do so. We recommend the adoption of the report as printed in the Handbook, pages 84 to 89 inclusive. (Motion seconded by Dr. Nay and passed.)

Report of Committee on Venereal Disease. Your reference committee moves the adoption of the report of the Committee on Venereal Disease as printed in the Handbook, pages 89 to 91, and commends this committee for its careful consideration of many serious problems of great concern to the local health unit and especially to the local practitioner of medicine. We have particular reference to article 2, page 90, of the committee's report. (Motion for adoption of this section carried.)

Report of the Committee on Industrial Health. The report of the Committee on Industrial Health,

pages 91 to 94 inclusive in the Handbook, has been given careful consideration, and your reference committee is impressed with the amount of time, energy and effort that this particular committee has given to the problems concerned with the medical profession as related to industrial health. The report of this committee is commended and we recommend its adoption by the House of Delegates of the Indiana State Medical Association. (Motion for adoption of this section carried.)

Report of the Anti-Tuberculosis Committee. Your reference committee has carefully reviewed the report of the Anti-Tuberculosis Committee as printed in the Handbook on pages 94 to 96, inclusive, and wishes to commend this report as one of the best evidence of an active, alert, interested group of medical men concerning a problem that touches everyone in every walk of life. We recommend its adoption, and so move. (Motion seconded, and carried.)

Committee on Conservation of Vision. We recommend the adoption of this report as printed in the Handbook on page 97. (Motion seconded by Dr. Catlett, and passed.)

Report of Committee on Hard of Hearing. We recommend the adoption of this report as printed in the Handbook, pages 103 to 105 inclusive. (Motion for adoption seconded by Dr. Garceau, and passed.)

The resolution presented to the association from the Delaware-Blackford County Medical Society as presented by Dr. Clay Ball is also approved by your reference committee on Hygiene and Public Health. We recommend that the officers of the association be instructed to put in motion action which will bring about the provision of proper educational facilities for any crippled child in the State of Indiana. We move the adoption of this resolution. (Motion seconded by Dr. Nay, and carried.)

William H. Garner, M.D., *Chairman.*
L. W. Painter, M.D.
Harold D. Caylor, M.D.
Harry P. Ross, M.D.
S. M. Cotton, M.D.

Dr. Garner: I move adoption of the entire report as a whole. (Motion seconded, and carried.)

AMENDMENTS TO CONSTITUTION AND BY-LAWS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

Your committee met with Dr. A. W. Cavins, who is chairman of the Committee on Revision of the Constitution, and discussed the report as contained on pages 119 and 120 in the Handbook. After careful study this committee recommends the adoption of the report of Dr. Cavin's committee, as presented, which proposes the deletion of Article IX, Section 4, of the Constitution, which reads as follows:

> "Sec. 4.—The Councilors shall be elected by the respective district societies, providing that if any district shall exist without a society, or if the district society fails to meet and elect its Councilor and notify the House of Delegates before or at the time of the Annual Session, the Councilor for such a district shall be elected by the House of Delegates. Provided further, That if a Councilor district society fails to meet and elect its Councilor, the Councilor for that district shall be elected by the House of Delegates."

and replacing that by new Section 4, as proposed in this report, which reads as follows:

> "The Councilors shall be elected by the respective district societies, provided that if any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election."

This committee further recommends that in case of adoption of this recommendation by the House of Delegates that the Executive Committee of the State Medical Association bring to the attention of each District the probable necessity for examining their District Constitution and By-Laws to insure provision for the replacement of a Councilor due to death or permanent incapacity of any such officer.

C. V. Rozelle, M.D., *Chairman.*
Raymond C. Beeler, M.D.
Oran A. Province, M.D.
Gordon A. Thomas, M.D.
R. Lee Smith, M.D.

Dr. Rozelle: I move you that this report be accepted and that this amendment be made to the Constitution. (Motion duly seconded, and carried.)

The President: This is an amendment to the Constitution and has to be laid over until the next session. The report can be accepted as it is but the final action depends upon the next House of Delegates.

REPORTS OF OFFICERS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The Reference Committee on Reports of Officers met, and after examining the following reports, moves their adoption as printed in the Handbook, with the exception of the address of the president, which was delivered before the general meeting,

and the president-elect's address before the House of Delegates at the first meeting:

Treasurer's report.
Report of the Executive Secretary.
Report of the Chairman of the Council.
Report of the Executive Committee.
Report of the Journal Publication Committee.

(Motion for adoption of this section of the report carried.)

The supplementary report in regard to raising the dues from $10.00 to $15.00 per year is submitted to the House of Delegates for discussion and decision without specific recommendation from this committee.

O. G. Brubaker, M.D., *Chairman.*
E. R. Clarke, M.D.
G. L. Verplank, M.D.
C. F. Briggs, M.D.
R. B. Johnson, M.D.

Dr. Brubaker: I move the acceptance of this recommendation. (Motion seconded by Dr. Combs, and carried.)

Dr. A. M. Mitchell: I make a motion that the dues of this society be raised from $10.00 to $15.00, beginning with the new year of 1947. (Motion seconded by Dr. Garceau and Dr. Combs.)

Dr. George Daniels: I wish to amend that by making the increase $2.00; that is, $12.00 per year. (Motion seconded by Dr. Clarke, Howard county. On vote, this motion was lost.)

(The House then voted on Dr. Mitchell's motion to increase the dues $5.00, making the membership dues $15.00 per year beginning January 1, 1947, and this motion was passed.)

COMMITTEE ON CREDENTIALS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

The only report assigned to the Reference Committee on Credentials was the report of the Committee on Credentials as published in the Handbook on page 35. The committee approves that report and moves its adoption.

Carl M. Clark, M.D., *Chairman.*
J. Frank Maurer, M.D.
John S. Hash, M.D.
Floyd S. Napper, M.D.
Gilbert D. Rhea, M.D.

(Motion for adoption of this report carried.)

MISCELLANEOUS BUSINESS

House of Delegates,
Indiana State Medical Association.

Gentlemen:

1. We commend the Committee on Arrangements for the excellent work they have done in making the arrangements for this convention.

2. We commend the conduct of the Secretaries' Conferences and recommend the adoption of the report of the Secretaries' Conference Committee.

3. We recommend the continuation of the liaison between the Committee on Necrology and History and the Centennial Celebration Committee and recommend that they continue to work together in preparation of the centennial memorial volume. We move the adoption of the report of the Committee on Necrology and History.

4. This committee wishes to commend Doctor Bird for the fine work done during the war and during this first postwar period. We recommend the acceptance of the report of this committee and recommend consolidation of this committee with the present Committee on Veterans' Affairs.

5. No report was submitted by the Committee on Postwar Medical Service but we recommend consolidation of this committee with the present Committee on Veterans' Affairs. (Motion for adoption of this portion of the report carried.)

6. Report of Committee on Medical Economics. We concur in the recommendations of this committee, to wit: (1) That there be increased emphasis by the Indiana University School of Medicine on courses in economics. We recommend that a letter expressing the desires of the association in this matter be sent by the Executive Committee to the acting dean of the medical school. (2) We concur in the recommendation of this committee that one meeting of each county medical society each year be devoted to economic problems. (3) We recommend that the House of Delegates empower the Committee on Medical Economics, in collaboration with Mr. Stump and the executive secretary, to proceed with the compilation and publication of a medical blue book of Indiana, this to cover common laws applying to physicians, simplified income tax rulings, state and inheritance taxes, and other matters of common interest to physicians. (Motion for adoption of this portion of the report carried.)

7. We recommend the adoption of the report of the Medical Advisory Committee for Vocational Rehabilitation.

8. We recommend the adoption of the recommendations of the Building Committee as embodied in this committee's report.

9. We recommend adoption of the report of the Veterans' Affairs Committee.

10. We recommend the adoption of the report of the Veterans' Care Committee.

(Dr. Topping moved the adoption of this portion of the report and the adoption of the report in its entirety. Motion seconded, and carried.)

M. C. Topping, M.D.
A. E. Stinson, M.D.
King L. Hull, M.D.
A. A. Thompson, M.D.
Frederick K. Allen, M.D.

Dr. Daniels: I would like this House to pass this on to the local medical society, its members and committees; in fact, all who took part in the entertainment of this meeting in Indianapolis. It has been one of the best I have ever attended, and I therefore move you that this word be con-

veyed to the Marion County Medical Society, that we all have had a good time and appreciate very much their type of entertainment. (Taken by consent.)

DR. HAUSS: I feel that it is in order, and only justice, in view of the splendid work here, that this House of Delegates pass a vote of confidence to Dr. Norman Beatty and the Legislative Committee. I so move you, Mr. President. (Seconded, and passed unanimously.)

DR. E. VERNON HAHN: This should be said. I am sure that all of us and this society, the Indiana State Medical Association, have enjoyed a year of great accomplishment under the very competent leadership of Dr. Jesse Ferrell, and I am sure I have not attended any meeting of the state medical association which has been conducted any better than this current convention. I wish to move that it is the sense of this House of Delegates that Dr. Ferrell has conducted our affairs in an exemplary, admirable way during the past year, and to express our appreciation for his earnest efforts and his great skill. (Taken by consent.)

DR. FERRELL: I certainly appreciate your confidence. . . . I am proud of our accomplishments this year. They have not been through my efforts alone but through the working of every committee, our state office, and everyone concerned. I wish to pay especial appreciation to Dr. Romberger who took my place a number of times when I was unable to attend.

Organized medicine is the strongest organization in the world today, if we only knew it. The only trouble is we just don't exert our power. I recall having an interview with Ex-Governor McNutt one time on legislative matters, in which he said: "The medical profession has more power than any organization that I know of in the world today." I thought that was a pretty good tribute to organized medicine.

To your oncoming president I offer my sincerest congratulations. I'll be at his back at all times. If I can be of any help, he has only to call, and I assure you that he will carry on to the glory that is due the Indiana State Medical Association. With that, I thank you from the depth of my heart.

(It was taken by consent that the House send a message of good wishes to Dr. J. T. Oliphant, past president of the association, who is ill.)

(The President extended thanks and appreciation to the Indianapolis newspapers and the various press services for the impartial way in which publicity for the convention had been handled, and also to the radio station which gave time for a broadcast during the meeting.)

No further business appearing, on motion of Dr. Daniels, the 1946 session of the Indiana State Medical Association adjourned.

EXECUTIVE COMMITTEE

September 29, 1946.

Roll call showed the following present: Cleon A. Nafe, M.D., chairman; C. H. McCaskey, M.D.; J. E. Ferrell, M.D.; F. T. Romberger, M.D.; A. M. Mitchell, M.D.; A. F. Weyerbacher, M.D.; and Ray E. Smith, executive secretary.

Guest: J. T. Oliphant, M.D.

Membership Report

Number of members Sept. 28, 1946	3,429*
Number of members Sept. 28, 1945	3,361
Gain over last year	68

* Includes 843 in military service, 344 World War II veterans, and 155 honorary members.

Treasurer's Office

The Executive Committee directed the treasurer to prepare a report showing anticipated revenue of the association and THE JOURNAL for 1947 for submission to the Executive Committee and the Council.

Statements of receipts and expenditures for July and August for the association committees and THE JOURNAL were approved.

1946 Annual Session, Indianapolis, October 29, 30, 31, 1946

Annual Dinner.

a. The Executive Committee approved extending an invitation to two representatives from each of the three Indianapolis dailies and each of the three press associations.

b. Dr. Charles N. Combs is to take care of the seating of the ex-presidents and their wives, the councilors and their wives, and the wives of those seated at the speakers' table.

c. The after-dinner program will be held in the Murat Theater.

Commercial Exhibit.

The committee voted not to take insurance covering loss or damage of exhibitors' property.

Bodily Liability Insurance.

The committee approved taking $10,000-$100,000 coverage, to cost $117.00, for the duration of the convention.

Recognition of Mr. Hendricks.

Presentation of a gift in recognition of his many years of service with the Indiana State Medical Association is to be made by Dr. Ferrell at the annual dinner, immediately after presenting the certificate to the past president.

On motion of Doctor Romberger, seconded by Doctor McCaskey, the Maternal Health League was granted space in the exhibit hall during the annual session.

Request of Dr. W. U. Kennedy for time on general program to speak on Mutual Medical Insurance, Inc.

Upon the motion of Doctor McCaskey, seconded by Doctor Romberger, the decision as to place on the general program for Doctor Kennedy was left to Doctor Nafe and the executive secretary.

Request from the American Medical Association for passage of a resolution calling for full-time public health organizations on a county, joint county, or district basis, was referred to the Committee on Public Policy and Legislation for presentation to the House of Delegates if the legislative committee sees fit.

Organization of Alumni of Indiana University School of Medicine.

The committee agreed to provide a table near the registration desk for alumni of Indiana University School of Medicine to register their intentions of becoming members of an alumni association of the medical school.

Legislative Matters

National.

Taft Bill, S. 2143.

On motion of Dr. Mitchell, seconded by Dr. McCaskey, the letter from the Council on Medical Service of the American Medical Association asking for suggestions for improvement of S. 2143 (Taft health bill) was referred to the president-elect with the suggestion that he study the 1946 bill and confer with the president. The decisions for amendments to the bill then are to be sent by Dr. Romberger to the Council on Medical Service.

National Health Legislation.

Letter from the California Medical Association suggesting that resolutions opposing compulsory health insurance be submitted to various organizations outside the medical profession for adoption, was referred to the Legislative Committee.

Local.

Annual Registration Bill.

a. Dr. Oliphant discussed the preliminary draft of the annual registration bill, and the following five recommendations for inclusion in the bill were adopted:

1. That an emergency clause be incorporated in the bill.
2. That the annual registration period be of sixty days' duration instead of thirty.
3. That the bill meet the approval of the members of the Indiana State Board of Medical Registration and Examination before its introduction in the legislature.
4. That in the next to the last paragraph the words "unless the Board is in doubt as to whether the applicant for reinstatement is qualified to continue to practice in accordance with the certificate which had been canceled" be eliminated because this gives discretionary powers to the Board.
5. That Section 2 of the bill state that the funds collected are to be used for "necessary personnel and in the performance of its (the Board) duties as fixed by law."

b. The Executive Committee went on record as favoring an amendment to the present medical practice act which would give the State Board of Medical Registration and Examination authority to issue temporary permits to practice medicine in Indiana pending examination by the Board.

Pre-legislative Meeting of Indiana State Chamber of Commerce.

The co-chairmen of the Legislative Committee and the executive secretary were authorized to attend a pre-legislative meeting to be sponsored by the Indiana State Chamber of Commerce November 24, 25 and 26, 1946, and authorized the expenditure of $15.00 for registration, upon the motion of Doctor Mitchell, seconded by Doctor Romberger.

Prepayment Medical Care

Report on progress of Mutual Medical Insurance, Inc., was made by the treasurer.

Organization Matters

State Fair Exhibit.

a. Report made that the following tests were made in the Health Building at the State Fair:

Depth perception	2,520
Color vision	3,062
Blood pressure	4,260
	9,842

b. The executive secretary reported that the resolution passed by the Council of the Indiana State Medical Association asking that medical quacks be forbidden at the State Fair had been approved and followed by the State Fair management.

The executive secretary reported on details of the 1946 annual session of the Michigan State Medical Society.

Advisory Committee of the Medical Assistance Program.

Request of the Indiana State Department of Public Welfare for appointment of a technical committee to work with the present State Advisory Committee on Medical Assistance was referred to the chairman of the State Advisory Committee on Medical Assistance for presentation to the House of Delegates at its next meeting.

National Radio Program.

The committee voted to cooperate with the Bureau of Health Education of the American Medical Association in a nationwide radio program. The request for historical information was referred to the chairman of the Centennial Celebration Committee. The selection of a speaker to broadcast over WIRE on January 25, 1947, was deferred until the next meeting.

A.M.A. Resolution on Submission of Resolutions.

The executive secretary explained the new regulations of the American Medical Association House of Delegates which require submission of resolutions for presentation to the House thirty days in advance of its meetings.

State Board of Health

The president explained the survey being made by the American Academy of Pediatrics.

The chairman of the Executive Committee presented the plans of the Indiana State Board of Health and Purdue University for making a joint study of undulant fever. The Executive Committee gave its approval.

Dr. George V. Cring's request to discuss the food handler's certificate before an official body of the Indiana State Medical Association was considered, and it was decided that he should take this matter up before the Council.

It was decided that the letter which the Indiana Division of Food and Drugs is enclosing with the state laws on filling prescriptions should call attention to the penalty which may be assessed physicians and pharmacists for violations.

Postwar Medicine

Contract with Veterans Administration.

The secretary reported that the contract with the Veterans Administration had been approved as of August 1, 1946, and that the fee schedule was being printed for mailing to members of the association. Each member then will be asked whether or not he wishes to participate in the program.

The executive secretary reported that the information about the Indiana medical profession's part in World War II had been turned over to the Indiana War History Commission at a conference in Bloomington on September 11 and that the medical profession was one of the first to complete its history.

Letter from Dr. W. D. Gatch

The chairman read a letter received from Doctor Gatch in response to the letter sent to him by the Executive Committee following his resignation as dean of the Indiana University School of Medicine.

Coming Medical Meetings

The Secretaries-Editors Conference, and the House of Delegates meeting of the American Medical Association will be held December 7 to 11 in Chicago.

The Journal

Report on Advertising:

Additions	$1,250.77
Decreases	36.00
Total increase during August and September	$1,214.77
Total increase over budget estimate, 1946	$5,460.17

Indiana Brewers Association Advertising.

Letter received from a member of the Indiana State Medical Association objecting to THE JOURNAL accepting advertising from the Indiana Brewers Association was referred to the chairman of the committee and the executive secretary for answer.

Report on St. Paul Mercury Indemnity Company.

The chairman of the Executive Committee reported that the St. Paul Mercury Indemnity Company has 344 policies in effect covering members of the association.

There being no further business, the meeting was adjourned.

PENICILLIN PROPHYLAXIS RECOMMENDED BY AMERICAN HEART ASSOCIATION

Penicillin was revealed today as an effective agent in preventing one of the most deadly forms of heart disease known as subacute *bacterial endocarditis*, an infection which occurs in patients who have rheumatic heart disease. Prior to the advent of penicillin this disease was practically always fatal. Almost one-half of the cases of this infection develop after a tooth extraction or an operation on the upper air passages.

Drawing upon recent medical research, the American Council on Rheumatic Fever, of the American Heart Association, advocated today that all persons suffering from rheumatic fever or rheumatic heart disease receive treatments of penicillin before having a tooth extracted or undergoing any other operation on the upper respiratory tract.

Stressing the need for national education on this new use for penicillin, Dr. Homer F. Swift, Chairman, declared at the Council's annual meeting at the Hotel Lexington that "bacterial endocarditis is a serious infection of the heart valves and is caused by one of the streptococcus germs commonly known as 'green strep,' which is always present in the mouth and air passages." "When a tooth is extracted," he added, "the bacteria enter the blood stream and grow on one of the heart valves previously damaged by rheumatic fever.

"If the patient receives penicillin prophylaxis prior to the extraction of a tooth, or any mouth or throat operation, the disease can be prevented. Where this is not done, and the disease develops, penicillin administered in large doses and over a long period of time can cure the majority of cases."

Members of the American Council on Rheumatic Fever, representing medical organizations, public health agencies, social workers, and child care groups, approved a policy calling for an informational campaign directed at physicians and dentists as well as the general public regarding the value of this preventive use of penicillin. Dentists will be urged to avoid extracting teeth of patients having rheumatic heart disease unless penicillin has first been administered. Physicians will be asked to cooperate in providing such treatments, and in informing parents of the need for penicillin therapy before any surgery is performed on the nose or mouth of a patient with a record of rheumatic heart disease.

"It is our objective," Dr. Swift said, "to urge all patients now listed on a rheumatic fever registry in any community to consult first with their physicians on the possibility of penicillin treatment prior to any operation. If this procedure is instituted in the community rheumatic fever program, cases and deaths from bacterial endocarditis will be prevented."

Among the delegates attending the annual meeting of the Council were representatives of the American Academy of Pediatrics, American Association of Medical Social Workers, American College of Physicians, American Heart Association, American Hospital Association, American Medical Association, American Nurses Association, American Public Health Association, American Rheumatism Association, American School Health Association, National Organization For Public Health Nursing, National Society for Crippled Children and Adults.

THE JOURNAL
OF THE
Indiana State Medical Association

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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Banyai, Andrew Ladislaus (Pneumoperitoneum Treatment) ____ August 1
Barber, Marshall A. (A Malariologist in Many Lands) ____ June xxxvi
Bergler, Edmund (Unhappy Marriage and Divorce) ____ June xxxvi
Brunner, Hans (Intracranial Complications in Ear, Nose and Throat Infections) ____ December xxxvi

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Castle, William B.; Stroud, William D.; Eusterman, George B.; Dick, George F.; Amberson, J. Burns; and Minot, George R. (The 1945 Year Book of General Medicine) ____ April xxxiv
Christian, Henry A. (The Principles and Practice of Medicine) ____ June xxxvi
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Painter, Charles F. (The 1945 Year Book of Industrial and Orthopedic Surgery)—April xxxiv

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Wiener, Meyer (Ophthalmology in the War Years) (Volume I)—October xliv

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Aged (Geriatrics), The Care of the (Thewlis), The C. V. Mosby Company—April xxxiv
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Bibliography of Infantile Paralysis, 1789-1944, A (Hektoen-Salmonsen), J. B. Lippincott Company—October xliv
Blind Hog's Acorns, Vignettes of the Maladies of Workers, A (McCord), Cloud, Inc.—August 1

Clinical Medicine, Modern Management (Albrecht), The Williams & Wilkins Company—August 1
Communicable Diseases, Handbook of (Top) (r), The C. V. Mosby Company—April xxxiv
Cornell Conferences on Therapy (Gold), The Macmillan Company—August 1
Courage and Devotion Beyond the Call of Duty (Second Preliminary Edition) Mead Johnson & Company—December xxxvi

Diabetes, A Concise Presentation (John), The C. V. Mosby Company—August 1
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BUREAU OF PUBLICITY

September 30, 1946.

Present: H. G. Hamer, M.D., chairman, and Ray E. Smith, executive secretary.

The first general story about the annual session was approved for distribution to daily and weekly newspapers.

Copy was approved for the following "Hints on Health" columns:

Week of October 21, 1946—"Avoid Sleeping Pills."

Week of October 28, 1946—"Cold Time Is Here."

Week of November 4, 1946—"Diphtheria."

Request for speakers:

November 15, 1946—Woman's Auxiliary to the St. Joseph County Medical Society. "Mutual Medical Insurance, Inc." Speaker obtained.

May 21, 1947—Parent-Teacher Association, School 38, Indianapolis, 3:00 p. m. "Poliomyelitis." Speaker obtained.

Report on meeting:

September 19, 1946—State convention, American Federation of Labor, Tomlinson Hall, Indianapolis. "Prepayment Medical Care."

BUREAU OF PUBLICITY

October 14, 1946.

Present: Karl R. Ruddell, M.D., and Ray E. Smith, executive secretary.

Copy was approved for the following "Hints on Health" columns:

Week of November 11, 1946—"Fibroids are Common."

Week of November 18, 1946—"Pernicious Anemia."

Week of November 25, 1946—"Gall Bladder Diseases."

The following news releases about the forthcoming annual session were approved:

1. Names of committees in charge. For Indianapolis newspapers only.
2. General Medicine theme at session of state doctors.
3. Outstanding men in medicine will address doctors.

The executive secretary was directed to send out a news release to daily and weekly newspapers on resolution in opposition to compulsory health insurance adopted by recent national American Legion convention.

The minutes of the meetings of the Council and the House of Delegates, appearing in this issue, are comprehensive reports of the transactions of the governing bodies of the association during the recent annual meeting. Read them!

INDIANA STATE BOARD OF HEALTH

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—August, 1946

Diseases	August 1946	July 1946	June 1946	August 1945	August 1944
Tuberculosis, Pulmonary	296	119	378	0	0
Tuberculosis, other forms	19	5	30	0	0
Chickenpox	21	55	263	20	11
Measles	22	111	1012	22	16
Scarlet Fever	63	35	165	52	55
Paratyphoid Fever	1	3	0	....	0
Typhoid Fever	11	30	6	5	13
Whooping Cough	100	101	172	135	62
Diphtheria	18	8	21	17	18
Influenza	2	0	0	17	6
Pneumonia	11	9	17	1	3
Mumps	24	56	94	37	9
Septic Sore Throat	26	15	22	8	0
Poliomyelitis	98	21	9	43	108
Cerebro-Spinal Meningitis	5	7	6	5	10
Non-epidemic Meningitis	4	0	0	1	0
Undulant Fever	24	22	26	5	6
Erysipelas	2	0	0	1	2
Impetigo	3	8	3	0	0
Encephalitis	8	0	0	4	2
Rocky Mt. Spotted Fever	4	0	0	8	2
Infectious Jaundice	1	1	0	7	0
Trachoma	4	0	0	0	0
Vincent's Angina	5	5	1	0	0
Tularemia	4	2	0	0	0
Rubella	2	1	24	4	0
Typhus Fever	1	0	0	0	0
Amebic Dysentery	1	2	0	0	0
Tetanus	1	0	2	1	0
Malaria, outside U. S.	27	33	18	5	0
Malaria, unknown source	0	1	0	0	10
Keratoconjunctivitis	0	0	0	0	3
Opthalmia Neonatorum	0	0	0	0	2

DIVISION OF COMMUNICABLE DISEASE CONTROL

Monthly Report—September, 1946

Diseases	Sept. 1946	Aug. 1946	July 1946	Sept. 1945	Sept. 1944
Tuberculosis, pulmonary	292	296	119	171	160
Other Tuberculosis forms	19	19	5	6	6
Chickenpox	35	21	55	34	35
Scarlet Fever	87	63	35	87	100
Measles	16	22	111	16	9
Paratyphoid Fever	....	1	3	1	....
Typhoid Fever	9	11	30	17	13
Whooping Cough	88	100	101	87	52
Diphtheria	18	18	8	31	35
Influenza	20	2	....	12	14
Pneumonia	10	11	9	7	6
Mumps	19	24	56	30	22
Septic Sore Throat	6	26	15	....	4
Poliomyelitis	124	98	21	77	108
Cerebro-Spinal Meningitis	8	5	7	13	5
Non-Epidemic Meningitis	1	4	....	....	1
Undulant Fever	18	24	22	6	2
Impetigo	8	3	8	....	....
Encephalitis	18	8	....	6	....
Rocky Mountain Spotted Fever	6	4	....	....	....
Infectious Jaundice	3	1	1	2	....
Tularemia	1	4	2	....	1
Rubella	2	2	1	....	2
Amebic Dysentery	2	1	2	....	....
Tetanus	3	1	2	3	1
Malaria Outside U. S.	16	27	33	8	....
Malaria, Unknown Source	5	....	1	....	....
Food Poisoning	3	....	....	....	....

The Season's Greetings



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To dress the fir tree in its gift attire
To wish you happiness and cheer
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LOCAL SOCIETY REPORTS

Bartholomew County Medical Society members met at the Noblitt-Sparks Cafeteria, Columbus, on October twenty-third. A very interesting talk was given by Dr. Paul D. Crimm, of Evansville. His subject was "Surgical Treatment in the Care of the Tuberculosis Patient." Doctor Crimm illustrated his talk with lantern slides. The meeting was attended by twenty-four members and guests. Following the talk a business session was conducted.

Cass County Medical Society members held a meeting at Logansport on September twentieth. Dr. J. W. Jackson, of the Indiana State Board of Health, presented a paper on "Immunization of Pre-school Children." Fourteen members were present.

Another meeting was held at the St. Joseph Hospital, Logansport, on October eighteenth. Dinner was served to the fifteen members present. Films on "Intocostrin in Surgery and Anterior Poliomyelitis" were shown.

Delaware-Blackford County Medical Society members held a meeting at the Hotel Roberts on October fourteenth with thirty members present. George L. Clark, V. S., Vice-President of the Indiana State Veterinary Medical Society, Columbia City, presented a paper on "Undulant Fever in Animals."

Floyd County Medical Society members held a dinner meeting at the New Albany Country Club, New Albany, on October eleventh. Dr. Thomas H. Hewlett and Dr. J. M. Paris, New Albany, presented papers on "Treatment of Severe Burns" and "Streptomycin in Tularemia." Twenty-two members and one guest were present.

Greene County Medical Society members met at the Freeman Greene County Hospital on October seventeenth. Dr. L. A. Malone and Dr. Joseph G. S. Weber, of Terre Haute, discussed "X-ray Problems and New Technique." A motion picture was shown by the Abbott Company, entitled "Intravenous Pentothal Sodium for General Anesthesia." Dinner was served to the twenty members present.

Hancock County Medical Society members held a dinner meeting at the James Whitcomb Riley Hospital on October sixteenth. The chief topic of discussion was the possibility of the construction of a hospital for Hancock County. The speakers were Dr. Leroy E. Burney, Indianapolis, and Dr. W. U. Kennedy, New Castle.

Hendricks County Medical Society members met at Crawley's restaurant on October fifteenth, to discuss plans for the construction of a hospital in Hendricks County. Dr. C. B. Thomas, of Plainfield, and Dr. O. T. Scamahorn, of Pittsboro, were appointed to present the subject to the Hendricks County Commissioners.

Indianapolis (Marion County) Medical Society members held a meeting at the White Cross Service Center, Methodist Hospital, on November fifth. A Symposium on Digotoxin was conducted by Dr. Kenneth G. Kohlstaedt and Dr. K. K. Chen, both of Indianapolis.

A second meeting was held on November twelfth. Dr. Ralph U. Leser, of Indianapolis, discussed "The Use of Anti-Histamine Group of Drugs in Internal Medicine"; Dr. Kenneth L. Craft, of Indianapolis, discussed "The Use of Anti-Histamine Group of Drugs in Otolaryngology"; Dr. Frank M. Gastineau, of Indianapolis, discussed "The Use of Anti-Histamine Group of Drugs in Dermatology"; and Dr. Bennett Kraft, of Indianapolis, discussed "The Use of Anti-Histamine in Allergy."

At a third meeting, held on November nineteenth, Dr. C. Basil Fausset, of Indianapolis, spoke on "The Cervical Disc Syndrome," and Dr. Frederic W. Taylor, of Indianapolis, spoke on "Gunshot Wounds of the Abdomen at City Hospital."

At the fourth meeting held on November twenty-sixth Dr. A. J. Micheli, of Indianapolis, discussed "Tumors of the Ovary," and Dr. John H. Warvel, of Indianapolis, discussed "Management of Diabetes Mellitus."

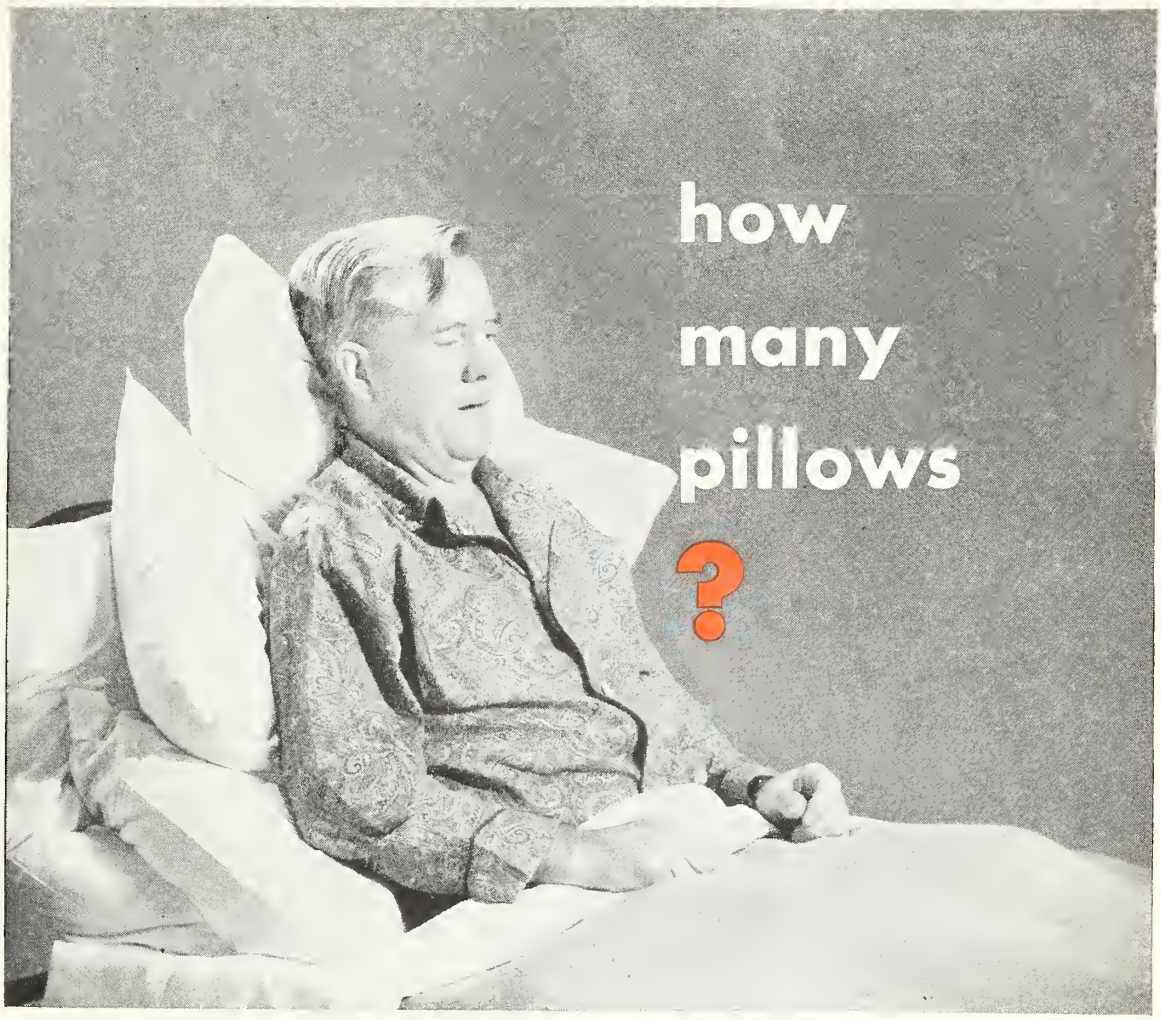
LaPorte County Medical Society members met at the Rumley Hotel on October seventeenth, to hear Dr. J. Stanley Battersby, of Indianapolis, speak on "Gastro-Intestinal Bleeding in Children." Nineteen members were present.

TENTH COUNCILOR DISTRICT

The Tenth Councilor District meeting was held in conjunction with the Lake County Medical Society on October tenth, at Phil Schmidt's Restaurant, in Hammond.

Dr. Benjamin A. Cockrell, Chief Medical Officer, Veterans' Administration, Chicago Regional Office, and Dr. C. H. Ogden, Assistant Chief, discussed "The Veterans Administration's Medical Program" and "Home-town Care and Cooperation of Family Physician."

The dinner meeting was attended by eighty members.



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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

WOMAN'S AUXILIARY to the Indiana State Medical Association

President—Mrs. S. J. Petronella, East Chicago.
President-elect—Mrs. A. W. Ratcliffe, Evansville.
Corresponding Secretary—Mrs. David Eisenberg, Hammond.
Recording Secretary—Mrs. J. L. Allen, Greenfield.
Treasurer—Mrs. Wendell Kelly, Anderson.
Press and Publicity—Mrs. O. H. Bakemeier, Indianapolis.

CONVENTION NOTES

The attendance at the convention this year was the greatest in the history of the Indiana State Medical Association. A most interesting and constructive program was carried out for both the doctors and their wives.

The Auxiliary activities opened with the State Board meeting on Tuesday afternoon, October twenty-ninth, in the Murat Temple Lounge, at which time Mrs. S. J. Petronella welcomed Fulton County, our newest Auxiliary. She also read a report of the National Convention held in San Francisco in June.

Brief reports were given by the Board members. A change was made in the Amendment to the Constitution, Article 5, Section B, which read, "The House of Delegates shall meet prior to May first in Indianapolis," to read "The House of Delegates shall meet prior to May first at a place designated by the Executive Board." The meeting will be held on the last Tuesday and Wednesday in April, in Indianapolis.

The Nominating Committee members were elected to serve with Mrs. Frank Gastineau, Councilor, who heads the committee, and Mrs. A. W. Ratcliffe, president-elect. They are Mrs. F. S. Cuthbert, Kokomo; Mrs. A. P. Hauss, New Albany; and Mrs. B. W. Harris, Gary. A membership of one thousand and forty, including members-at-large, was reported.

At the close of the committee reports Dr. Walter Stoeffler, pediatric consultant for the Indiana State Board of Health, gave a short talk on the national child survey which is under way, and financed by the Federal Government. Some eight thousand dollars will be expended in Indiana under the direction of the State Board of Health and the American Academy of Pediatrics. "The objective," he said, "is to make available to all mothers and children of the United States all essential preventive diagnostic and curative medical services of high quality, which, used in cooperation with other services for children, will make this country an ideal place for children to grow into responsible citizens."

Mrs. Clifford Richey, of Evansville, was appointed to the office of third vice-president, to fill the unexpired term of Mrs. Arthur Richter, of Indianapolis, who resigned. Mrs. Richey will serve until the election, which will take place at the meeting of the House of Delegates next April.

Mrs. John W. Carmack, of Indianapolis, was chairman of arrangements for the women's entertainment. She was assisted by the members of the Marion County Auxiliary.

Tuesday night a Hallowe'en dinner party was held in the Athenaeum when the Marion County president welcomed the guests, approximately three hundred. After Mrs. S. J. Petronella, state president, greeted the dinner guests and introduced her Executive Board, the ladies went across the street to join their husbands for a theater party in the Murat Temple.

Wednesday morning the annual business meeting was held in the east room of the World War Memorial. Mrs. S. J. Petronella, president, presided. The meeting was opened with the Pledge of Allegiance, followed by the Auxiliary collect. The county presidents were introduced.

Mr. Rollis Weesner, of Hammond, Executive Secretary of the Lake County Medical Society, gave a most inspiring talk, using as his subject "The Layman Looks At Political Medicine." He stated "that 54 per cent of the people didn't know what was proposed in the Wagner-Murray-Dingell Bill. Medicine has always been socialized, in that it has always been in the field of social welfare. Medicine is a state obligation. We expect the state to do construction of bridges and roads for our safety, but we don't expect the state to take over our expense when we have an accident on those constructed roads or bridges. We depend on insurance. The public needs to know the physiological effect socialized medicine would have upon the doctor's attitude. The laity is not particularly interested in socialized medicine but the emotions are aroused by story-mongers."

Mrs. John W. Carmack announced that at the close of the meeting the members were invited to visit the shrine in the building.

Closing the morning session Mrs. Truman Caylor, Bluffton, conducted the memorial service, quoting from poems, such as Jean Ingelow's "Memory"; Rupert Brooke's "Death"; and verses from the Psalms and Revelations. As she lighted the candle she said "This candle I light in memory of those vibrant personalities who are gone from our midst. It burns brightly as an inspiration and beacon to stimulate the interest and endeavors of us who carry on. It is our privilege to finish the pattern of the tapestry which their planning helped to create."

Mrs. Roy A. Geider, Marion County, September 2, 1946.
Mrs. Jack E. Pilcher, Marion County, October 5, 1946.
Mrs. R. D. Denman, Steuben, North Eastern Academy.
Mrs. M. C. Topping, Vigo County, May, 1946.
Mrs. Chas. W. Wyeth, Vigo County, September, 1946.

A luncheon was held in the Columbia Club following the general business session, when Dr. N. K. Forster, of Hammond, gave a talk on the topic "The Shape of Things to Come." He remarked that "It seems likely that the principal job for the doctor of medicine in the next ten years, working with his associates in other fields, will be to maintain democracy in medicine and in civil life



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* Brereton, T.C.: Canad. M.A.J. **54**:358 (April) 1946.



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generally. It is quite likely that the general hospital of the future will be the base of modern medical service. It will include not only laboratories, equipped and manned to provide diagnostic services, but increasingly will provide determinations to guide the doctor in the control of therapeutic procedures. It will include an out-patient service for follow-up rehabilitation, ambulatory and home treatment. It will provide office facilities for practitioners who, on the basis of geographic full time, can greatly increase their effectiveness and service to the community at lowered cost and with greater satisfaction to themselves."

After the luncheon lovely door prizes were given those whose names were drawn, and table prizes were given for bridge.

The women accompanied their husbands to the Annual Banquet, Wednesday night, in the Murat Temple dining-room, and then to a program in the theater, where Mr. Thomas Hendricks "pinch-hit" for Olin West, M.D., Nashville, Tennessee, president-elect of the American Medical Association.

The entertainment speaker was Jack Major, of Paducah, "The Colonel from Kentucky," whose subject was "Horses, Women and Hogs."

COUNTY NEWS

Delaware-Blackford

The Medical Auxiliary has made the Mock School for Crippled Children their project for this year. The Auxiliary hopes to furnish a number of books, special scrap-books, and other necessary materials for the children. Five members of the Delaware-Blackford Medical Society are members of the Mock School Board.

Porter County

The Woman's Auxiliary has been very active this fall, having already had their third meeting. On September twenty-fourth they had a dinner party at the home of Mrs. J. C. Brown, followed by a short business meeting, and movies shown by Mrs. C. M. Davis of their trip through the western states. On October twenty-second the auxiliary members attended a meeting of the American Home Department of the Woman's Club, to hear Mrs. John Stambaugh speak on the subject "Bill 1050." On November twenty-sixth the regular monthly meeting was held with Mrs. H. O. Seipel, 302 Lafayette Street, Valparaiso.

Wells County

The first meeting of the Woman's Auxiliary was a dinner meeting at the Bluffton Country Club, in October, with their husbands as guests. The program included committee reports and a report by Mrs. Allen C. Nichol on the national convention in San Francisco.

Seven Auxiliary members attended the state meeting. Mrs. Truman Caylor, the county president, gave the memorial services at the state meeting.

Mrs. S. J. Petronella, State President, was a guest in November.

Books

RECEIVED

DIFFERENTIAL DIAGNOSIS OF JAUNDICE. By Leon Schiff, M.D., Associate Professor of Medicine, Department of Internal Medicine, University of Cincinnati; and Director, Gastric Laboratory, Cincinnati General Hospital. 313 pages with 38 illustrations. Price $5.50. Cloth. The Year Book Publishers, Inc., Chicago, 1946.

COURAGE AND DEVOTION BEYOND THE CALL OF DUTY (Second preliminary edition). A partial record of official citations to medical officers in the United States Armed Forces during World War II. 1014 pages. Mead Johnson & Company, Evansville, 1946.

MEDICAL USES OF SOAP (Second edition). Edited by Morris Fishbein, M.D., Chicago, Editor of The Journal of the American Medical Association. 195 pages with 41 illustrations. Cloth. J. B. Lippincott Company, Philadelphia, 1946.

HYGIENE. By Florence L. Meredith, M.D., Professor of Hygiene and Public Health, Tufts College, Boston, Massachusetts. (Fourth edition.) 838 pages with 155 illustrations. Cloth. Price $4.00. The Blakiston Company, Philadelphia, 1946.

INTRACRANIAL COMPLICATIONS IN EAR, NOSE AND THROAT INFECTIONS. By Hans Brunner, M.D., Associate Professor of Otolaryngology, University of Illinois College of Medicine, Chicago. 444 pages with 95 illustrations. Cloth. Price $6.75. The Year Book Publishers, Inc., Chicago, 1946.

REVIEWED

ANESTHESIA IN GENERAL PRACTICE. By Stuart C. Cullen, M.D., Head of Division of Anesthesiology, Department of Surgery, State University of Iowa Hospitals; Associate Professor of Surgery (Anesthesiology) State University of Iowa College of Medicine. 260 pages with 36 illustrations. Cloth. Price $3.50. The Year Book Publishers, Inc., Chicago, 1946.

Every practitioner should acquaint himself with the recent marked advances in anesthesia, and while he need not take the time to study more voluminous and detailed texts, he at least should read this little book.

If he has a patient who is to be subjected to surgery he should be able, in that patient's interest, to judge whether or not the anesthetist employed is using this recent knowledge advantageously and whether or not his surgeon is aware of modern methods which reduce mortality and morbidity.

The chapter of Curare is of special interest as Doctor Cullen is foremost in the clinical use of this adjunctive agent in anesthesia.

The style of the text is readable and understandable to the doctor in general practice and yet has a stimulating appeal to the most advanced anesthesiologists. It reflects the accumulated experience of a conservative but most profound investigator.

The comic cartoons detract from the dignity of the presentation but do serve to strike terror in the heart of any one who is careless in treatment.

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News Notes

Dr. Hiram T. Sexson, of Greenfield, has moved to Indianapolis, where he will establish the practice of medicine.

Dr. Alton H. Ridgway, of Indianapolis, who was recently released from service, is now a resident physician at the St. Francis Hospital in Beech Grove.

Dr. J. W. Freeman has opened medical practice in New Castle, and has taken over the practice of Dr. E. K. Westhafer, who recently retired. Doctor Freeman was a resident physician at Ball Memorial Hospital, in Muncie, for a year, and served four and one-half years in the Army, spending twenty months of that period in England.

Dr. Donald J. McNairy has recently begun the practice of dermatology, and is associated with Dr. Samuel R. Mercer, of Fort Wayne. Doctor McNairy served as surgeon in the United States Public Health Service for two years, and has also served a three-year fellowship in dermatology at the Mayo Clinic.

Dr. Hubert R. Dagley, who entered the armed forces in July, 1944, is planning to open on office in Hope, December first. Doctor Dagley had obtained a commission in the Army Reserve at Indiana University and at the time of entering service received a commission as captain in the Medical Corps. Doctor Dagley served in the European theatre, principally in Germany, where he was attached to the Twentieth Armored Division. During the last six months of his Army career he served at Halloran General Hospital in Staten Island, New York.

The centennial meeting of the Aesculapian Society of the Wabash Valley was held at the Country Club of Terre Haute on October twenty-fifth. The theme of this year's meeting of the society was exemplified by a doctor representing his professional forbears of the 1840's, who drove through Terre Haute's business district in a horse and buggy of ancient vintage. Just outside the city he was met by a number of other doctors on horseback, each with a medicine kit slung over his saddlebags. Indiana doctors who appeared on the program were Drs. Stuart R. Combs, M. C. Topping and James F. Spigler, all of Terre Haute, and Dr. James M. Anderson, of Vincennes. Dr. E. O. Nay, of Terre Haute, is president of the society and spoke at the dinner meeting.

Dr. Bruce A. McArt, of Edgewood, and Miss Patricia Scott, of LaGrange, were married at the Presbyterian Church in LaGrange, on October twentieth. They will reside in New York City where Doctor McArt is serving his internship at Greenpoint Hospital, after graduating in April from the Indiana University School of Medicine.

Allen County physicians have formed an association of Allen County Physicians, World War II, and at the organizational meeting on October tenth elected Dr. A. R. Savage, of Fort Wayne, president. Other officers elected include Dr. Arthur J. Roser, vice-president; Dr. Leslie Wilson, secretary; and Dr. Charles J. Cooney, treasurer. All eligible physicians in the county will be asked to join the society. Approximately fifty doctors now form the nucleus of the organization. The aim of the association is to improve the professional, social, and fraternal interests of the members.

Dr. Julius C. Travis, Jr., who has recently been discharged from the Army following thirty-nine months of service, has resumed the practice of medicine limited to diseases of the ear, nose and throat at 402 K. of P. Building, Indianapolis. Prior to going overseas, Doctor Travis was stationed at Bowman Field, Louisville, Kentucky, and with the Troop Carrier Command, Army Air Base at Alliance, Nebraska. He served eleven months in the Pacific, on New Guinea and Leyte, where he was squadron surgeon of the advanced echelon of the Headquarters squadron. Later, for eight months, he was stationed at Mitchell Field, Long Island. He was a captain at the time of separation.

CENTRAL STATE HOSPITAL OF INDIANAPOLIS REPRESENTED AT LATIN-AMERICAN MEDICAL MEETING IN MEXICO CITY

The Central State Hospital, of Indianapolis, has been invited to show the scientific exhibit on "The Treatment and Prevention of Syphilitic Optic Atrophy" at the convention of the Latin-American Medical Association in Mexico City, November 17-23, 1946.

New treatment schedules combining penicillin with malaria fever, which will arrest primary syphilitic optic atrophy, will be demonstrated to Latin-American physicians. Dr. Walter L. Breutsch, research director of Central State Hospital, will be in charge of the exhibit.

Co-sponsors of the exhibit are the American Society for the Prevention of Blindness and the American Social Hygiene Association.

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After four years of work as resident surgeon at the Maris Hospital, at Williamsport, Dr. Thomas C. Haller has left for St. Louis, Missouri, where he will take postgraduate work at Washington University.

Dr. and Mrs. John O. Butler, of Indianapolis, stopped in THE JOURNAL office recently. Mrs. Butler is the former Dr. Martha Crandall, and was the first woman physician to enter the Army Medical Corps from Indiana. She entered service in July, 1944, and after two months training as assistant ward officer at the Lawson General Hospital, in Atlanta, Georgia, she was transferred to the Madigan General Hospital, at Fort Lewis, Washington. She spent sixteen months there as chief of contagious disease section, and the remaining time until her separation in January, 1946, as chief of Women's and Children's Section.

Dr. John Butler also entered service in July, 1944, and after six weeks at Carlysle Barracks was sent to Moore General Hospital, at Swannanoa, North Carolina. It was there that he and Mrs. Butler were married, on August 26, 1944. He remained there until October, and then went to Camp Campbell, Kentucky, where he joined the 20th Armored Division as battalion surgeon for the 20th Tank Battalion. This division landed in LaHavre in February, 1945, then crossed Europe and eventually ended up in Munich. Dr. Butler has battle stars for action in the battle of Central Europe and the battle of the Rhineland. He was awarded the Silver Star for directing the collecting and treatment of wounded men while under heavy sniper fire that killed two of his men. He was returned to the United States for redeployment, but the end of the war changed that and he was sent to the Madigan General Hospital, where he was chief of the Officers' Section, on the Medical Service. He was later transferred to the Pulmonary Diseases Section, and served in that capacity until his separation on October eighteenth. Doctor Butler is associated in the practice of medicine with Dr. J. T. Oliphant, in Farmersburg, and Mrs. Butler is quite occupied with caring for their three months' old son, but plans to re-enter practice in the future.

INDIANA UNIVERSITY NEWS NOTES

Three Indiana University scientists, aided by grants from the American Cancer Society, will join in the nation-wide million dollar research attack on cancer.

William H. Ball of Muncie, president of the Indiana Cancer Society, advised President Herman B Wells today that the American Cancer Society, with which the Indiana organization is affiliated, had assigned research grants totalling $10,500 to Professors Allan C. G. Mitchell, H. J. Muller, and S. E. Luria of the I. U. faculty.

The grants, which were made possible through contributions to the Indiana Cancer Society, include $6,000 for biophysical and biochemical studies of virus growths by Professor Mitchell, head of the physics department, and Professor Luria of the bacteriology department. Two other grants aggregating $4,500 for research in genetics in relation to cancer have been made to Professor Muller of the department of zoology.

The research aid was given on recommendation of the National Research Council and is the first to be made available to Hoosier scientists. Under the national cancer research program the American Cancer Society is awarding research grants and fellowships amounting to approximately $1,000,000 to chemists, physicists, biologists, physicians and surgeons throughout the United States for investigations in all possible fields that may contribute to man's knowledge of cancer and its control.

Mrs. Eugenia K. Spalding, regarded as one of the country's leaders in the field of nursing education, has been named director and professor of nursing education at Indiana University, where she will be in charge of the advanced nursing education program. Mrs. Spalding came to the Indiana University faculty this fall from Catholic University, Washington, D. C., where she has been an associate professor of nursing education.

The new University director of nursing education is a former president of the Indiana State Nurses Association and in 1921-29 was executive secretary of the Association and educational director of the Indiana State Board of Examination and Registration for Nurses. She received her professional training at the St. Vincent's Hospital School of Nursing, Indianapolis, where she later served as assistant director and instructor.

She holds the B.S. and M.A. degrees and a special diploma in administration of schools of nursing from Teachers College, Columbia University. Keuka College, New York, conferred on her several years ago the honorary D.H.L. degree.

During the war Doctor Spalding was associated with the United States Public Health Service in various posts, including that of coordinator of staff education in the Office of Nursing.

The University also has announced the appointment of Miss Ruth Ileene Gillan as instructor in nursing education. Miss Gillan is a graduate of St. Mary's Mercy Hospital School of Nursing, Gary, and has the B.S. degree from the University of Wisconsin and the A.M. degree from the University of Chicago.



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Deaths

Morton L. Bridge, M.D., of Marion, died on November third, at his home, following a long illness. He was seventy-six years of age. Doctor Bridge was a graduate of the Rush Medical College, in Chicago, in 1896.

Francis Elsworth Hypes, M.D., of Nappanee, died on July thirteenth, at the age of sixty. He was a graduate of the Indiana University School of Medicine, in Indianapolis, in 1913, and was a veteran of World War I. Doctor Hypes was a member of the Elkhart County Medical Society, the Indiana State Medical Association, and the American Medical Association.

John W. Thompson, M.D., of Garrett, died at his home on October seventeenth, following an illness of four years. He was sixty years of age. Doctor Thompson graduated from the Rush Medical College in 1909. He was a veteran of World War I, having served eighteen months in the medical corps. He was a member of the DeKalb County Medical Society, the Indiana State Medical Association, and was a Fellow of the American Medical Association.

Claude E. Ragsdale, M.D., of Trafalgar, died at the age of seventy-seven. Doctor Ragsdale graduated from the Medical College of Indiana, in Indianapolis, in 1894.

David G. Pryor, M.D., of Jeffersonville, died at his home on October twenty-seventh, at the age of forty-three years, following a short illness. He graduated from the University of Louisville School of Medicine in 1931. Doctor Pryor was a member of the Clark County Medical Society, the Indiana State Medical Association and the American Medical Association.

Clarence C. Bosselmann, M.D., of Plymouth, died at his home on November seventh, at the age of thirty-six. He had been a lieutenant (jg) in the Navy, having served in Iceland during the early days of the war. Doctor Bosselmann graduated from the Indiana University School of Medicine, in Indianapolis, in 1935, and was a member of the Allen County Medical Society, the Indiana State Medical Association and the American Medical Association.

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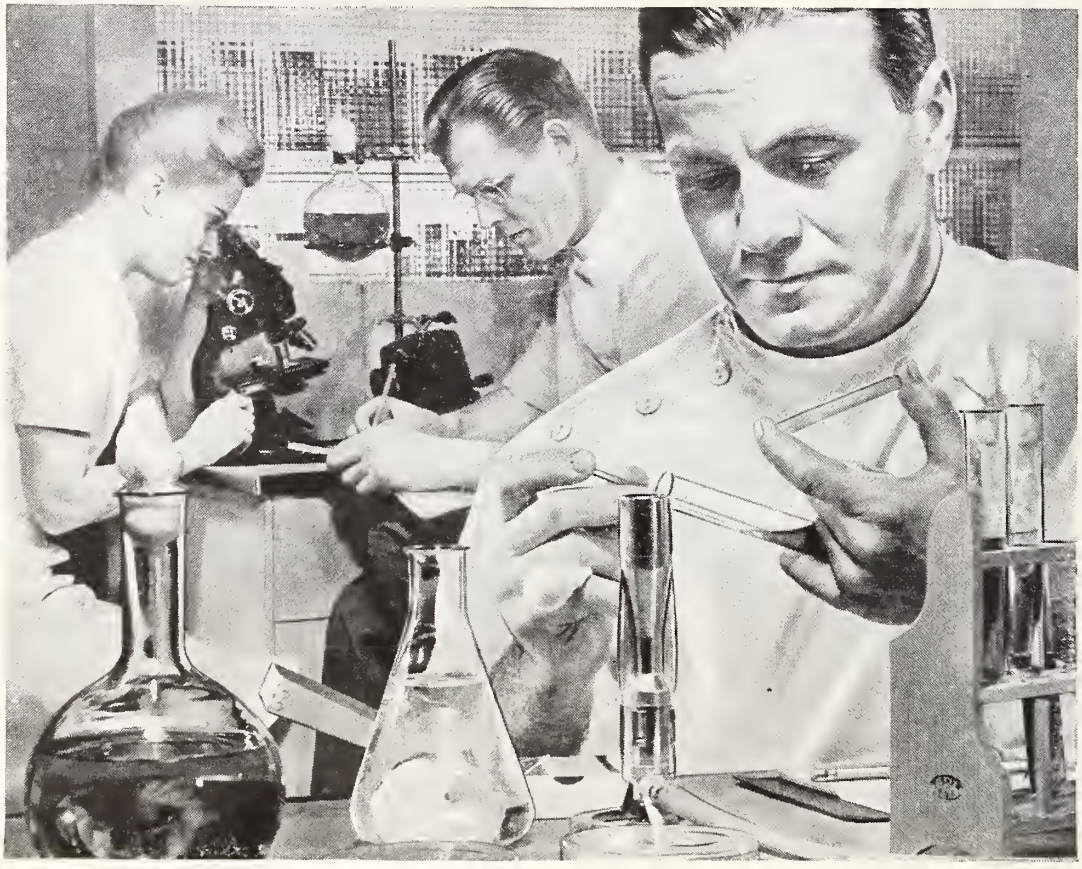
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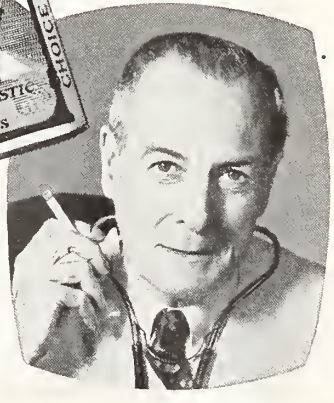


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EARLY VITAMIN DEFICIENCY STILL POSES PROBLEM TO MEDICAL SCIENCE

Although health education and commercial advertising have made the American public diet and vitamin conscious, medical science is still faced with the problem of detecting and treating early vitamin deficiency states, according to David Cayer, M.D., of Winston-Salem, N.C.

Writing in the November 9 issue of *The Journal of the American Medical Association*, Dr. Cayer, who is from the Department of Internal Medicine, Bowman Gray School of Medicine of Wake Forest College, says that it is very difficult to recognize early vitamin deficiency states when physical signs are absent. These include night blindness, spongy bleeding gums, painful joints and sore tongue and mouth.

Symptoms alone are not an accurate guide for diagnosis. As an example, the author cites the similarity of the symptoms of neurasthenia or nervous exhaustion and early vitamin deficiency, both of which manifest fatigue, insomnia, nervousness, headache, depression, muscle weakness, backache and lassitude.

In conclusion, the author says: "Primary deficiency states can be avoided by the proper selection of foods in the daily diet. Low economic status or reduction in the total food intake to provide for shipment abroad need not reduce the qualitative value of the diet. An adequate diet is still obtainable in this country, even for families of low income, and in spite of reduction in the total intake to provide for shipment of food abroad."

Four doctors report in the same issue of *The Journal* the results of severe deficiency disease seen mostly in white and half-breed Costa Rican children who subsisted on a diet consisting chiefly of bananas and molasses.

The doctors—Antonio Peña Chavarría, C. Saénz-Herrera and E. Cordero-Carvajal from the Department of Pediatrics of the San Juan de Dios Hospital, San José, and Leon Goldman from the Department of Dermatology and Syphilology of the College of Medicine of the University of Cincinnati—noted changes in the children's hair from slight graying to intense whiteness. The hair "becomes loosened and is easily pulled out of the scalp," they say.

This condition, the authors believe, is caused by a deficiency of one of the less well known members of the vitamin B complex group. The children can be treated successfully if they survive the severe vitamin deficiency state. Improvement can be produced by a general, adequate diet or with a mixture of vitamin B complex.

The addition of biotin, one of the most potent known members of the vitamin B complex, "is thought, but not proved," to accelerate the return of both the pigmentation and growth of the hair, according to the authors.

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